ADMINISTRATION'S PROPOSED ELIMINATION OF THE OFFICE OF DIRECT REIMBURSEMENT AT THE HEALTH CARE FINANCING ADMINISTRATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

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ADMINISTRATION'S PROPOSED ELIMINATION OF THE OFFICE OF DIRECT REIMBURSEMENT AT THE HEALTH CARE FINANCING ADMINISTRATION

WEDNESDAY, SEPTEMBER 14, 1983

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room B-318, Rayburn House Office Building, Hon. Andrew Jacobs, Jr. (chairman of the subcommittee), presiding.

[The press release announcing the hearing follows:]

[Press release of Thursday, Aug. 25, 1983]

Hon. Andy Jacobs, Jr. (D., Ind.), Chairman, Subcommittee on Health of the Committee on Ways and Means, Announces a Hearing on the Administration's Proposed Elimination of the Office of Direct Reimbursement at the Health Care Financing Administration

Hon. Andy Jacobs, Jr. (D. Ind.), chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a public hearing on the administration's proposed elimination of the Office of Direct Reimbursement at the Health Care Financing Administration (HCFA). The hearing will be held on Wednesday, September 14, 1983, beginning at 10 a.m. in room B-318 of the Rayburn House Office Building.

BACKGROUND

For most hospitals, skilled nursing facilities and home health agencies, medicare payments for covered services to beneficiaries are made through intermediaries. Intermediaries are private insurance firms or Blue Cross plans acting as agents of the medicare program under contract with HCFA for the processing of claims for payment and other related activities.

Under existing medicare rules, however, some providers of services can elect to receive payment directly from the Federal Government rather than through an intermediary. The Office of Direct Reimbursement (ODR) carries out HCFA's function of reimbursing those medicare providers who elect to be reimbursed directly by the Federal Government.

Section 1874 of the Social Security Act gives the Secretary the authority to perform directly or by contract any of the Secretary's functions under medicare. Under this authority, the Secretary is proposing to contract out the functions of making payment determinations, disbursing payments and related activities with respect to providers and other entities that are currently serviced directly by the Office of Direct Reimbursement at HCFA. Proposed regulations, with a 30-day comment period, were published on August 2, 1983, announcing these proposed changes.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests in writing by close of business Tuesday, September 6, 1983, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses scheduled to appear before the subcommittee are required to submit 100 copies of their prepared statements to the main committee office, room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Because of time constraints, organizations with similar views may be asked to consolidate their testimony.

Each statement to be presented to the subcommittee and any written statement submitted for the record must contain the following information:

1. The name, full address, and capacity in which the witness will appear (as well as a telephone number where he or his designated representative may be reached);
2. A list of any clients or persons, or organization for whom the witness appears; and
3. A topical outline or summary of comments and recommendations.

For those who wish to file a written statement for the printed record of the hearing, six copies are required and may be submitted by the close of business on Friday, September 16, 1983, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office during the hearing.

Chairman JACOBS. Our hearing today is convened to consider the administration's proposed elimination of the Office of Direct Reimbursement at HCFA.

Our first witness for the Department is Daniel Bourque of the Health Care Financing Administration. I assume that every witness knows the rule from the New York State Athletic Commission: 5 minutes per witness. Please consider the fact that at the end of the line, it gets rather late in the day and you do a kindness to be punctual in your testimony. There is the usual price of $1 for the most concise testimony, and it is a Susan B. Anthony dollar and a Kennedy half for the runner-up.

You may proceed in your own manner within our rules, sir.

STATEMENT OF DANIEL P. BOURQUE, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JAMES L. SCOTT, ASSOCIATE ADMINISTRATOR FOR OPERATIONS

Mr. BOURQUE. Thank you, Mr. Chairman.

My name is Daniel Bourque. I am the Deputy Administrator of the Health Care Financing Administration, and to my is right, Mr. James Scott, Associate Administrator for Operations.

It is a pleasure to be here today to attend this hearing and present the administration's position. As you know, Mr. Chairman, the administration has proposed to phase out the direct claims payment operations of HCFA. This is not a new or recent idea, nor are we the only administration to have considered this action.

Our rationale is primarily twofold. First, as a management decision, we in HCFA are faced with many new programs, as you know: the hospice program, all sorts of waivered activities required through the reconciliation process, prospective payment, PRO's, and a host of other activities that require additional resources within our agency.

These additional activities come at a time when attrition alone has reduced HCFA's employment base by several hundred people over the last couple of years. We desperately need the ability to shift valuable personnel resources in order to continue to assure the public we are responsibly and effectively managing the very large medicare and medicaid programs.

Second, in deploying our scarce resources, we are continually looking for functions we know can be efficiently done by the private sector. Over 95 percent of our claims-processing activities are currently done through private contractors: Blue Cross-Blue Shield plans and commercial insurance companies acting on our behalf. This has been an effective and efficient system for us for many years and this was the way Congress authorized and intended the program to be run in 1965.

In accomplishing the phaseout plans, we have examined carefully those who might be impacted by these moves, primarily our employees and medicare providers. We believe we have and will take measures which will minimize the impact on these groups.

Our ODR staff are a valued resource to HCFA. We need their skills elsewhere. I have personally assured them that no one will lose their employment with our agency as a result of this phaseout. We will find an appropriate job at the same grade and pay rate as they currently have, or, if warranted and a promotion is necessary, we will try and find that, too, elsewhere in the agency. We have set up several personnel programs and strategies to carry this out.

For the providers, many of whom, I might add, have informally discussed with us a voluntary transfer, special efforts are being made to secure a smooth transition. First, we have made commitments to the home health associations and others that we will only transfer them to intermediaries able to accept their automated or electronic claims processing systems. We do not intend to turn back the clock on management efficiency in this program.

Second, for the multistate chain providers, we have agreed to allow them to select one compatible intermediary to handle all their claims work. Their concern has been that if they were transferred to a variety of intermediaries, it would disrupt their operations. We have told them that we would select one intermediary for them that will handle all their needs across many States.

Third, we have agreed to develop and implement new additional performance criteria for our contractors in order to insure that they offer and provide appropriate services to the providers.

Finally, we have agreed to establish within each of our 10 regional offices an ombudsman position to whom providers can go to resolve any problems they encounter with the transition to another intermediary.

In summary, Mr. Chairman, we think we have been responsive and responsible to both our employees and medicare's providers in effecting this management decision. We all seek to guarantee that medicare's beneficiaries are well served and that taxpayer dollars are well spent.

The private contractor system has accomplished this for us since medicare's inception and we expect it will continue in the future.

Chairman **Jacobs**. Thank you, Mr. Bourque; 4 minutes, 29 seconds.

[The prepared statement follows:]

STATEMENT OF DANIEL P. BOURQUE, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, I am pleased to be with you today to outline the Health Care Financing Administration's (HCFA) plans to improve overall program administration by phasing out the Office of Direct Reimbursement (ODR). With me is Mr. James L. Scott, Associate Administrator for Operations.

PROPOSED REGULATORY CHANGES

In light of its commitment to the most effective and efficient administration of the medicare program, this administration has carefully analyzed and reviewed the role of HCFA in the direct payment of medicare claims. The result of our careful study was a decision to phase out this direct payment activity. On August 2, a Notice of Proposed Rulemaking (NPRM) appeared in the Federal Register describing in detail our plans in this regard. I would like to briefly review the NPRM with you today.

About 200 hospitals, 40 skilled nursing facilities, 480 home health agencies, 70 health maintenance organizations, 380 Federal hospitals, 21 clinics and agencies furnishing physical therapy services, and 7 end stage renal disease facilities out of the approximately 12,800 providers and other entities that currently participate in the program receive payment directly through HCFA. (These are updates of the figures that were used in the NPRM.) In fiscal year 1982, these providers received benefit payments of about $800 million or 2 percent of total medicare payments.

Section 1874 of the Social Security Act gives the Secretary the authority to perform directly or by contract any of her functions under medicare. Under that authority, we are proposing to contract out the functions of making payment determinations, disbursing payments, and related activities with respect to providers and other entities that are currently serviced directly by ODR. Thus, we will require providers and other entities that currently deal directly with HCFA to deal instead with contractors that already are under contract with HCFA or other organizations with whom we contract in the future. However, it is our intention to carefully review each provider now using ODR to determine the least disruptive and most cost-effective arrangement for the long term. Those providers scheduled for transfer will be handled in a phased manner in order to assure an orderly transition.

We will make every effort to ensure that the transition is carried out smoothly; that there will be no disruption in cash flow; and that there will be no reduction in the level and quality of service. We will also assign an individual in each HCFA Regional Office (a provider ombudsman) to be responsible for addressing any provider concerns that develop during the transition process and thereafter. HCFA will continue to monitor intermediaries to assure adequacy of performance as required by current regulations.

We believe the new proposed regulation will, in the future, increase our ability to improve administration and program effectiveness for the following reasons:

In keeping with the President's goal to contract out to the private sector functions now performed by the government, HCFA wishes to withdraw from the direct claims processing business.

We intend to contract with existing or newly established medicare fiscal intermediaries whose accountants are also specialists in medicare principles of provider reimbursement.

With the new prospective payment system for hospitals and other reforms mandated by the Omnibus Budget Reconciliation Act of 1981 and the Tax Equity and Fiscal Responsibility Act of 1982, HCFA management needs the flexibility to move personnel resources where they are most needed and where such activities should not be contracted to other organizations.

BACKGROUND ON ODR

I think it is appropriate to discuss briefly the reason ODR was created in the beginning of the medicare program. In the early days of the program, critically important needs were met by ODR, but now we believe we must adjust the Federal role in providing direct reimbursement services. The background on the creation of ODR is particularly helpful in understanding our present position.

When the medicare program was enacted in 1965, the Congress sought administrative arrangements convenient to the medical care providers who were expected to participate in the new program. In the spirit of compromise which often accompanies far-reaching legislation, a deliberate decision was made to seek the help of private and nonprofit insurers. Their participation in the program as fiscal agents would help guarantee not only the medicare program's legislative success, but also its ultimate acceptance throughout the many localities in our Nation. In November 1963, the National Committee on Health Care for the Aged, which produced the blueprint for the program as it was later enacted, stated:

"Consistent with the principle of keeping the provision of health services of the aged in the mainstream of community services, the basic legislation establishing the plan should expressly authorize the designation of voluntary organizations as agents for the administration of benefits. . . . By utilizing existing voluntary mechanisms in the many areas where they are highly developed, we believe the best results will be obtained . . . acquisition of the necessary (Federal) staff . . . would represent a duplication of administrative resources which exist within one or more voluntary organizations in most areas of the Nation, resources which have the capacity and competence to provide efficiently the services required in the operation of the plan."

The intent of the National Committee—namely, that organizations with established relationships with local health care providers should be the preferred fiscal agents for the new program—was included in the administration's bill and completed the legislative process virtually intact.

During the legislative formulation of Medicare, certain local government interests (governments which operated hospitals, visiting nurse associations, and other providers), pressed for the right to deal directly with the Secretary. The law passed by the Congress specified that the Secretary would have the discretion to perform these services either directly or by contracting out. Thus, the Secretary was given absolute control over which organizations would enter into agreements to serve as fiscal agents. Further, the Secretary was given the right to reserve his/her approval of a provider's nomination of an agent.

As expected, many of the providers which originally chose to deal directly with the Federal Government were owned and operated by State and local governments. However, since the law also gave both intermediaries and providers mutual right of refusal, ODR acted as the fiscal agent of last resort for providers who did not care to deal with a given intermediary or were denied the services of that intermediary. This latter trend became particularly apparent as the Federal Government imposed increasingly sophisticated performance requirements on its contractors.

Gradually over the years, we have improved our ability to manage all phases of contractor performance. For instance, contractors may no longer refuse service to providers without extensive justification. This improvement in management of contractors, coupled with a lack of personnel and other Federal resources to devote to the direct reimbursement function, has historically tended to limit the size of ODR's workload, so that ODR currently processes only 5 percent of part A provider claims.

At this point in medicare's history, the administration believes that ODR has outlived its original purpose and usefulness. More importantly, ODR's experienced personnel are necessary in other parts of HCFA.

We, like the 1963 National Committee on Health Care for the Aged, believe that the claims processing function should be decentralized. HCFA simply cannot afford to devote an increasing proportion of its staff to a direct reimbursement function which we believe can be performed as well by the private sector. Instead, we believe HCFA's proper role is to focus upon those tasks which can be performed only by the Federal Government; for instance, implementing the recently enacted prospective payment plan for hospitals.

Our reasons for phasing down the ODR function are not based on dissatisfaction with ODR's performance. ODR's claims processing function is both automated and cost efficient, and its employees are among the most conscientious in the Agency. But we feel confident that our contractors can do the job as well as if not better than ODR, and the skills of ODR's personnel are desperately needed elsewhere in HCFA.

We are taking steps to assure that ODR's workload will be assimilated by our contractors with no disruption in service either to beneficiaries or providers. For example, we are adding standards of service for providers to the Contractor Performance Evaluation Plan (CPEP). In addition, we will honor the wishes of chain home health agencies who wish to deal with only one intermediary, and providers which wish to use magnetic tape processing. We have stated repeatedly to the home health agencies that we will not force them to retreat from the efficiencies they have gained. We intend to keep that commitment. We also intend to transfer agencies at the close of their accounting periods to facilitate a smooth transition.

Additionally, as I noted, we have created in each regional office an ombudsman to serve as a locus for provider complaints. Our years of experience of administering through contractors and the level of sophistication of our CPEP design assures us that we can maintain our current level of service to beneficiaries and providers. Finally, we have made a commitment to ODR employees to retain and place in similar jobs all who are affected by this change, and thus no HCFA employee will suffer any adverse consequences from this action. We believe, therefore, that we have thought through our proposal and that the transitional period will proceed smoothly for HCFA personnel, providers, and contractors.

I would like to remind the subcommittee that our strategy for managing the claims processing function includes a number of initiatives contained in the administration's fiscal year 1984 legislative proposals. These proposals would increase the Secretary's flexibility in entering into agreements for medicare claims processing by: Permitting the use of competitive or noncompetitive procurement processes; expanding the Secretary's authority to experiment with alternative contracting arrangements; and permitting contracts to be based on cost or other-than-cost reimbursement.

Although a great deal of progress has already been made in improving contractor efficiency through use of performance standards and budget negotiations, the existence of this additional authority would act as a motivating factor toward even more improvements by the contracting community-at-large.

These reforms in the contracting process could be accomplished at no cost in fiscal 1984 and would save nearly $3 million in fiscal 1985. By fiscal 1988, the annual savings would grow to $25 million. These reforms, plus the administrative actions we are already taking, would give us firm control on contractor management and assure continued improvement of efficiency in medicare claims processing. We hope the committee favorably considers our requests for legislative changes in the contracting process. However, even without these changes, we continue to believe that the elimination of ODR will serve the best interests of the medicare program.

Thank you for the opportunity to address the subcommittee. I will be happy to answer any questions you may have.

[The following was subsequently received:]

EXCHANGE OF COMMUNICATIONS WITH HCFA

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Washington, D.C., November 29, 1983.

Hon. ANDREW JACOBS, JR.,
Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. JACOBS: Thank you for your letter concerning our commitments to resolve issues raised at the September 14 hearing on our plans to phase out the Office of Direct Reimbursement (ODR).

Your understanding of our commitments is current. As Mr. Bourgue indicated in his letter of September 15, automated home health agencies (HHAs) will be transferred only when the intermediary has the same systems capability as the HHA had with ODR. This includes not only electronic claims processing but receipt and return of data such as admission notices, discharge data, plans of treatment and denial notices.

In response to your concerns, we are preparing an analysis of the impact on small business of our plans to phase out ODR. The analysis will appear in the final regulation, and we will invite public comments on that section.

The final regulation will allow all existing and newly established freestanding HHAs a choice of either the designated regional intemediary or an alternative designated regional intermediary. Although we have previously referred to the alternate intermediary as a "national" intermediary, the term should be "alternative designated regional intermediary" to reflect the fact that we plan to have different alternates available for HHAs in different parts of the country. We will provide in the final regulation for three alternate designated regional intermediaries to serve as "national" intermediaries. In addition, HHA chain organizations will have the opportunity to choose a single intermediary to process their entire workload.

We make these commitments in addition to our pledge to the employees in ODR. No ODR employee will lose his or her employment with the Federal Government nor will any ODR employee suffer a reduction in grade or pay as a result of this phaseout.

Mr. Jacobs, I hope this letter and the final regulation will assure you that we have carefully considered this action and that we will proceed with care and regard for the providers and ODR employees.

I am sending a similar to Representatives W. Henson Moore, Marty Russo and Barbara Mikulski.

Sincerely yours,

CAROLYNE K. DAVIS, Ph. D.,
Administrator.

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C., September 30, 1983.

CAROLYNE K. DAVIS, Ph. D.
Administrator, Health Care Financing Administration, Hubert Humphrey Building, Washington, D.C.

DEAR DR. DAVIS: We are writing to you in reference to the regulations published on August 2, 1983, to eliminate the Office of Direct Reimbursement (ODR) at the Health Care Financing Administration (HCPA). As you know, our Subcommittee held a hearing on this issue on September 14. A number of issues were raised at that hearing which concern us. We understand that you have been able to address some of the issues and we are writing to you to confirm our understanding of commitments made by your department.

First, a major concern expressed by home health agencies is that they will not be able to use their electronic systems capacity when they are transferred out of ODR. We understand that a commitment has been made that no home health agency will be transferred to their designated intermediary until that intermediary can serve the HHA with the same systems capability (this includes electronic claims processing, admission notices, discharge data, plans of treatment, denial notices, editing, screening, etc.) as the HHA had when it had been dealing with ODR. We feel strongly that no home health agency should be forced to use a less sophisticated computerized system or should be forced to return to a paper billing process if they have already moved on to electronic systems.

Second, as you know, we are concerned that no impact analysis was completed prior to publication of the proposed regulation as to its potential impact on small businesses. However, we understand that such an analysis will be included in the final regulation and public comment will be allowed on this analysis. We assume that the HCFA will be willing to consider comments received on this analysis and will be prepared to make adjustments in the regulation as warranted.

Third, considerable concern has been expressed that freestanding home health agencies, currently dealing with ODR, will not have a choice of intermediary under the proposed regulations. We understand that the final regulations will specify that home health agencies, currently dealing with ODR will have available, at the home health agency's election, a 'national' intermediary if they are dissatisfied with their designated regional intermediary.

These understandings listed above are in addition to the commitments already made to the employees of the Office of Direct Reimbursement. As stated by your Deputy Administrator at the Health Subcommittee hearing, no current ODR employee will lose their employment and there will be no reduction in grade or pay rate.

We remain concerned about the cost implications of this transfer and look forward to receiving additional information on the cost effectiveness of your plans.

The Ways and Means Subcommittee on Health will carefully review the final regulations and will be following closely their implementation. We look forward to your written response confirming these understandings at your earliest convenience. Thank you for your cooperation in this matter.

Sincerely,

W. HENSON MOORE,
Ranking Minority Member.
MARTY RUSSO,
Member, U.S. House of Representatives.
ANDREW JACOBS, JR.,
Chairman.
BARBARA MIKULSKI,
Member, U.S. House of Representatives.

Chairman JACOBS. Mr. Moore?

Mr. MOORE. Thank you, Mr. Chairman.

Mr. Bourque, is the notion of reducing or phasing out the Office of Direct Reimbursement something new or has this been going on for some time?

Mr. BOURQUE. Mr. Moore, it is an idea that has been considered ever since the consolidation of HCFA. Other administrations have considered this but have not gone as far as we have. This idea is not just a Reagan administration proposal, it is something that the Carter administration and others have considered.

Mr. MOORE. Has the size of the Office of Direct Reimbursement been the same over the years or has it been steadily getting smaller?

Mr. BOURQUE. It has gotten somewhat smaller in the last couple of years due to pressures having to do with transferring some of our employees and the natural attrition that has taken place. With the notion that we might phase out ODR, I think some employees have decided to look to greener pastures and have left.

So we have had a declining personnel number, but we are essentially at about 240 people, which is near full strength of a couple of years ago.

Mr. MOORE. What was the size of the agency originally? I had the notion that it was around 800 at one point. Was it ever that big?

Mr. BOURQUE. I don't believe the Office of Direct Reimbursement was ever that size, but it was probably at one point as many as 300 people.

Mr. MOORE. I know that is of concern, certainly, to the Members of Congress representing the area where most of these Federal employees live or work. I assume that is the Baltimore area, and the employees are very concerned about their future.

I heard you indicate you personally guaranteed them they were all going to be accommodated within the Department. I understand. Is there some notion that this is in their best interest in terms of career growth or are they somewhat stymied where they are now? If moved to other parts of the agency, would they have a better chance for advancement or promotion?

Mr. BOURQUE. Well, we think there are many advantages and opportunities for these employees. We have, as I mentioned, guaranteed that each of them would have another job, and I might add that they will be in HCFA and in the Baltimore area, unless they choose to go elsewhere.

We have set up a number of personnel programs that would deal with such a transition. We are offering a computer training program designed to develop qualified programers in grades 5, 7, and 9. We have a stride program which is an upward mobility initiative for selecting clerical and semitechnical people in grades 3 through 9.

We also have a professional development program for grades 9 through 12 which will help employees who may be interested in changing their particular activity or field within HCFA and allow them some promotional opportunity. In addition, we have the typing lab for improvement of typing and word processing skills.

So we really think that this is an opportunity for many employees who have probably been in the ODR operations for maybe as long as 10 years now and have not had the opportunities to move or to advance in that system, and now there are opportunities open.

I might add that we do have a desperate need for these people elsewhere. There are a lot of highly trained accountants and other individuals with claims processing skills that we can use in other parts of our agency, particularly our Bureau of Operations and Bureau of Support Services which does all our ADP work.

Mr. **Moore**. There seems to be a long list on the panel of witnesses to be heard from today from home health care providers.

What is the reason that this group in particular seems to be going to testify in opposition to this move and what have you done to satisfy these people?

Mr. **Bourque**. The home health agencies are concerned about several things, I think all of which we have addressed in one way or another.

I have met on a couple of occasions with the major associations and their representatives to discuss their concerns. I don't believe there is any area of their concern that we have not been responsive to. Primary on their list, I believe, is the notion that many of them came to the Office of Direct Reimbursement in order to take advantage of its electronic claims processing capability.

We have indicated to them that in those cases where we transfer them to an intermediary that cannot handle their claims in the same manner they now submit them, the intermediary will adapt its processes—including any needed software changes—in order to accept the claims.

As you may recall, in 1980 the Congress did ask us to regionalize our intermediaries for home health agencies which we accomplished fully last year. Through this process a lot of those regional intermediaries—all but just a handful—have upgraded their processes and their ability to accept electronic claims.

Frankly, if the particular intermediary in the area from which a provider comes can't do this, we have indicated we will find somebody who can, because we do not want home health agencies to have to revert back to a less efficient system.

Mr. **Moore**. What percent of the home health care agencies are having their claims directly reimbursed through this office?

Mr. **Bourque**. It is less than 15 percent, about 14 or 15 percent of all home health agencies that participate in the medicare program.

Mr. **Moore**. So 85 or 86 percent of the home health care industry is going through the private intermediaries system?

Mr. **Bourque**. Through the normal private contractor system; that is correct.

Mr. **Moore**. One last question and that is that there is some notion, I have been informed by staff and I understand from staff reports this morning, that the percent of error or the error rate of the Office of Direct Reimbursement is higher than the rate of the private contractors, is that correct?

And second, wouldn't that make it somewhat cost neutral to phase out this office since we would be saving money on incorrectly paid claims?

Mr. **Bourque**. Well, I think the operational statistics on ODR have really been varied. In some areas, it is clearly a more efficient processor of claims. It has a fairly low adjusted unit cost per claim.

But in a number of other areas that are just as important to us in handling our medicare workload, we find that it is not as efficient nor as effective as our other intermediaries.

One particular area that we are concerned about is the area of medical review, our ability to review the claims that come in and to make sure that these are appropriate claims for payment.

I might add that while our employees do what I think is a superb job at handling these claims, often it is not within their control to make sure that all these medical reviews get accomplished. The fact of the matter is that our inability to get technical people such as nurse specialists and other medical specialists within the agency, hurts us in being able to review these claims.

Back in the spring, I did detail some 14 separate individuals from other parts of our agency into the ODR operation, even while we were proposing this phaseout, in order to shore up the medical review activity because it is so important. And, as you know, you may be able to save a few dollars on the speed of claims processing but you can lose an awful lot more by not reviewing the claims and making inappropriate payments.

Mr. MOORE. In the case of onsite audit of providers, does the Office of Direct Reimbursement perform the same percentage of the same number of claims as does the private payors?

Mr. BOURQUE. The statistics show that it has not. From 1980 through 1982 there has been a rather marked difference.

For example, in hospital claims, the contractors in fiscal year 1981 audited over 24 percent of those cost reports; ODR audited only 2 percent. For skilled nursing facilities, it was 10 percent for the contractors, 2 percent for ODR. For home health agencies, it was 28 percent for our contractors and 2 percent for ODR.

So there has been quite a gap there, I think, and obviously if we move this workload to our intermediaries, we expect the amount of claims review to increase.

Mr. MOORE. Would the difference in this auditing, which is fairly substantial, be a difference in paying erroneous claims or paying claims?

Mr. BOURQUE. It would mean that we would pay fewer erroneous claims, I would suspect.

If we do more auditing, I think it has been demonstrated for every dollar we invest on the audit side, we get back anywhere from $5 to $12 on the program dollar side.

Mr. MOORE. So would this fact lead you to conclude that those who claim that doing away with ODR would, in fact, cost money, that this would be offset by the fact that ODR is not really doing the job it should in auditing?

Mr. BOURQUE. I believe there would be an offsetting factor. It is difficult to predict for whom and when, but I believe that that is the case.

Mr. MOORE. Mr. Chairman, you have been very generous with the time. I appreciate it and I have got no further questions.

Chairman JACOBS. Mr. Russo?

Mr. RUSSO. Thank you very much, Mr. Chairman.

In your testimony, Mr. Bourque, you talked about the health care agencies not having to worry about losing the automated billing system, that they will be transferred to intermediaries that can handle it. I assume, then, you are going to insist that those private intermediaries develop their own automated billing system?

Mr. BOURQUE. Mr. Russo, many of these intermediaries currently have automated billing systems and the ones that don't, we are encouraging to do so. In fact, we are making some investments not just for home health agencies but for the benefit of a broad array of providers. We are trying to increase the percentage of electronic data processing across the board in our program.

Mr. RUSSO. Is HCFA going to ensure that any of the traditional or startup costs that are associated with this change are going to be paid by the private intermediaries?

Mr. BOURQUE. The changes that are typically made by our contractors for claims processing work and audit work and so forth are a part of the normal costs that we do reimburse under the program.

We expect, however, that the changes that will come about through these transfers will be minimal. Our staff estimates that we are talking about software changes and for most of these intermediaries—and when I say "most," actually it is only a few of them—those costs will be in the neighborhood of about $5,000. When you think that we are running an $800 million operation, that kind of cost is really very minimal.

Mr. RUSSO. Does HCFA expect to save money as a result of dismantling ODR?

Mr. BOURQUE. We, in the short term, are not trying to save money through this. We are trying to better use the resources that we have.

We are predicating this move on what we expect will be awash, if you will, on the cost side. We think that we are in control of that situation because before any transfer takes place, we will be able to negotiate with an individual intermediary for accepting this additional workload. We think that we can negotiate favorable rates with them, rates similar to what we are incurring in terms of costs within ODR.

Mr. RUSSO. Let me ask you how you reconcile your recommendations with the comments of the President's private sector survey on cost control, which suggested in its analysis earlier this year that the proposed plan to eliminate ODR be reconsidered because HCFA will lose a significant value ODR provides as an in-house laboratory for special analysis and demonstration?

Mr. BOURQUE. The Grace commission did look at ODR along with the rest of our operations over a year ago and made a series of discrete recommendations and other comments for further study.

The ODR remarks were in the nature that we should reconsider what we were doing rather than being a formal recommendation to the agency to take some action.

The Grace commission mentioned a couple of things that I think are worth responding to. First of all, as you mentioned, ODR would be used as an in-house laboratory. I think that this reflects, really, a lack of understanding of how ODR has functioned over the years for us. I think it could be fairly said that at the beginning of the program when medicare was developing and evolving, ODR did some things that the private sector perhaps looked at and said, gee, maybe this is something we ought to do.

The fact of the matter, however, is that in the last several years, as our contractors have matured and our program has matured, ODR has been viewed less and less as a source of new ideas.

In fact, when the budget crunch came 2 years ago with the medicare contractors—where we got a level budget from one year to the next and the contractors were quite concerned—we initiated a program of productivity investments and initiatives to try and keep the costs down so we could live within our budget. This was handled entirely through the private sector and they are the ones that came up with the millions of dollars of savings that enabled us to meet our budget commitments.

I might also add that we do have within ODR a unit for demonstrations and this is comprised of 40 people out of the 240. We intend to keep those people. We may move them to our research and demonstration area within the agency, but we are going to keep that unit intact. We will continue to process claims for our hospice demonstrations, our alcoholism initiatives, and so forth. I think that if we choose to, we could use that group as the focus for any kind of experiment.

But the fact of the matter is that when the bulk of your program is run on the private side, you really need to test those ideas in the real world of what the private contractors are doing.

Mr. RUSSO. What happens if the private contractors don't do a good job for these agencies? What happens then? Who do they turn to? Who do they complain to? Does HCFA have somebody?

Mr. BOURQUE. Who does the provider complain to? There are really several avenues. We have a program called the contractor performance evaluation program [CPEP] which has criteria and standards which these intermediaries have to meet in order to comply with the contract. A lot of things in there are related to their responsiveness, their ability to deal with their providers.

I would not tell the subcommittee that we have not had difficulties in the past and I know that the home health community has been concerned about some of the interfaces they have had. Where that has been brought to our attention, we are trying to deal with those problems head on.

Mr. RUSSO. What have you done when you try to deal with them head on?

Mr. BOURQUE. First of all, we immediately get in touch with the intermediary to find out what the problem is and get the parties together.

Second, for this particular transfer, we have indicated that we will establish an ombudsman relationship for the transfer so things go smoothly. We are prepared to say that if an intermediary will not accommodate the home health agencies—and we don't know why they would not, but if they are not willing to—we will not force that provider to go to that intermediary. So there will remain an element of choice here.

Mr. RUSSO. Let me quote testimony from a witness that will appear later. He said:

> With the impending demise of ODR, we are becoming aware of instances of deterioration of the performance of some intermediaries. For example, some intermediaries are no longer willing to explain Medicare coverage guidelines to providers so they will know which cases Medicare will reimburse and the number and type of

visits that will be reimbursible. Some intermediaries have cut back on their telephone service, making it difficult to know whether particular cases would be covered.

My question is, Have you been hearing those kinds of complaints from home health agencies and, if so, what have you done about them?

Mr. BOURQUE. We have heard on occasion—some I heard personally in a meeting that I had with one of the associations—some of those concerns. I think that is absolutely intolerable. We should not be willing to put up with those situations because we are paying an awful lot of money to these contractors to run these programs.

Really the most direct recourse we have is to approach the intermediary and to remind it of its responsibilities in medical review and communicating with the provider.

There is an appeals process that works within the program where if claims have been denied, for example, there is an opportunity for the provider to sit down and discuss these and to get a rationale. We would be happy to receive from the home health associations or any particular provider their specific instances and I personally assure that we will follow up on those.

Mr. SCOTT. Mr. Russo, could I add a comment on that?

Mr. RUSSO. Sure.

Mr. SCOTT. As we have looked at this issue, we have tried to address the problem of the complaints in two ways. One is through our CPEP program that Mr. Bourque mentioned, which is the annual evaluation that we do of contractors. We are adding a new element to CPEP that really talks specifically about provider relations and the kinds of issues that you just addressed: Will the intermediary be meeting with providers and keeping them advised as to what is going on?

So we will be scoring our intermediaries on that element in addition to the other things we are looking at.

Secondarily, as Mr. Bourque mentioned, we have this ombudsman program and we are trying, outside of our normal management process, to identify in each region someone who an aggrieved provider can contact someone who can get directly to the regional administrator to see if there can be a resolution to a problem.

As the medicare program has grown and we have brought new kinds of providers into the program, some intermediaries have, quite frankly, been better than others at integrating new providers.

We think that these kinds of actions both in a general and in a specific sense should alleviate some of the concern.

Mr. RUSSO. Well, I think you should to make it known to your intermediaries that you don't want a lot of delays. And if there is a problem, then we need action on it quickly, because you are dealing with a significant program.

I have one last question. I helped draft the Regulatory Flexibility Act, which was signed into law by President Carter, and which required an impact analysis regarding the effect of regulations on small business. As I understand it, about 1,200 small businesses are affected by this particular proposal.

Why was such an analysis not completed?

Mr. **Bourque**. Our regulations, as you perhaps know, go through a fairly lengthy clearance process within the agency, the Department and the executive office of OMB. They reviewed our responsiveness to the Regulatory Flexibility Act and apparently did not feel at the time that such an analysis was warranted.

However, because of the interest and some of the concern expressed on this issue, we do intend to complete that and to furnish it with the regulation that we will finally submit.

We are really talking about less than——

Mr. **Russo**. Is the answer going to be it does not affect small business?

Mr. **Bourque**. No; I think we have admitted——

Mr. **Russo**. It appears you already know the answer and you need to prepare so the analysis suits the answer that you need, so you don't have a problem with the regulation.

This process is not supposed to be done backwards. It is supposed to be done before you produce the regulation. That is what disturbs me.

When I served on the Small Business Committee, and I was the chairman of the subcommittee that drafted this measure, nobody seems to care about small business. They do the analysis afterwards.

Well, we affect the small firms. We don't disturb the big providers and the big corporations and the big individuals. It is all right.

Now, again we are getting the same reaction. OMB says, "Don't worry about it." You come back with your own analysis. And frankly, my opinion is that your analysis will be what you need to prove that you are correct, which is not what was intended by the law.

I don't expect you to ever come back with an impact analysis now, that is going to kill your regulation when you have gone so far. Even if you prove you are going to have an adverse impact on 1,200 individual small businesses, you are going to say it will be minimal. If you say anything other than that, out goes your proposal to get rid of ODR.

Mr. **Bourque**. Congressman, I think we have been very straightforward in the regulation in admitting that there will be an impact on providers and how we would deal with that, so we are not trying to duck the issue of the impact. I think that if there is a strong feeling that the analysis has not been substantiated——

Mr. **Russo**. You will have a heck of a problem with me because you are going to have to face me a lot on this committee. Just to let you know, as somebody who helped draft that law and was instrumental in getting Jimmy Carter to sign it, you are not going to have an easy time dealing with me when you go around the Regulatory Flexibility Act.

OMB is an interesting bird. I have my own feelings about David Stockman. We served on the Commerce Committee together, and it seems to me that when OMB contracts a procedure they don't like, they knock the bones out of it and when it is something they want to do, they justify anything they want to.

The law is the law, and the law says you have to do the impact statement. So do me a favor: Don't come to this committee as long as I am a member and tell me you are going to do the analysis afterward, because you will have one hell of a time surviving this committee.

I am not trying to pick on you, but give the message back to David Stockman, will you? I will tell him personally, but you tell him you are the guy who has to take all the heat. He has been to the woodshed once already.

We don't pass these laws so that somebody can sit up there and tell the Congress to go hang it up. Small businesses are being adversely impacted by this administration's outlook on mergers.

As far as I am concerned, I don't want to have anybody who comes before our committee sidetrack the legal responsibilities they have in dealing with small businesses. I think that your administration and your agency especially ought to make sure they are not adversely impacted.

It burns me up, and I am sorry if it seems like I am taking it out on you, but Mr. Stockman is not in front of me. But hopefully, the TV cameras and the administration people here will take the message back to him that he must implement the laws as written, not as he thinks it ought to be done.

Chairman **Jacobs**. Ms. Mikulski.

Ms. **Mikulski**. Thank you very much, Mr. Chairman, for allowing me the opportunity to participate in this hearing in a collegial way.

As a member of the Waxman Subcommittee on Health and Environment on the Energy and Commerce Committee, I am vitally concerned about health care costs and particularly about the stability and continuity of the medicare program. It was for those reasons that I have introduced this act.

But to bring my questions to Mr. Bourque and picking up on some of the points made by my colleague, Mr. Russo, one of the questions I have for HCFA is that your responsibility as HCFA is to be both the keeper of the trust fund but also to be a keeper of the data base. Very often it is being the keeper of the data base that enables you to be the keeper of the trust fund.

ODR offered a unique opportunity to gather, keep, analyze, and strategize over the whole issue of home health care, probably one of the most potentially important sources of medicare expenditure, particularly in the coming years.

My question to you is, How will the contracting out, the dismantling of ODR still enable you to keep your mandated responsibility of being the keeper of the data base?

Mr. **Bourque**. Ms. Mikulski, the data base that HCFA maintains and keeps current is one that is primarily fostered by the contractors.

We have something that is called the PAT bill system that is kept in our data banks and contains program statistics across the country. This is an on-line system in which we get information that is sent in routinely on all the bills processed across the country for statistical purposes; utilization data, types of beneficiaries and so forth.

ODR represents a very small percentage of the claims that are entered into this system. The ODR claims and information from those claims go to the same system that all our contractors feed into.

For example, the largest concentration of providers in ODR is 15 percent of the home health agencies which means that only 15 percent of the data base that we are gathering on home health agencies is furnished by ODR. The other 85 percent comes from the rest of the contractor community.

So we expect absolutely no diminishment in the type and amount of data that we would collect. That data is submitted in a standard format so that the quality and integrity of the data is maintained.

Ms. MIKULSKI. Well, in my conversations with the home health care industry, they do not agree with you. And we will hear subsequent testimony about that. Because at ODR, you did have a one-stop shop where at least for that 15 percent, you could do that.

I am sure you would agree with me that certain of the home health care providers are interstate providers and that efficiency is a whole other issue, but by being able to watch it and monitor it using your own in-house computers, you could then observe trends and bring about recommendations for disciplines and reforms, innovations that just are not available by intermediaries.

Intermediaries are not meant to control costs. They are simply a passthrough, simply a conduit. They are not watching it. Blue Cross-Blue Shield has never been an aggressive cost controller except in very unique circumstances.

So I don't see how you can feel comfortable with that.

Mr. BOURQUE. Well, Congresswoman, I would take issue with the fact that our contractors are not concerned about cost control.

As you know, we have just initiated at Congress behest and based upon our original proposal a brandnew prospective payment program. We are spending millions and millions of dollars to establish the safeguards in that system to protect against erroneous payments on the part of providers and at the same time, of course, encouraging our intermediaries to be responsive in processing the bills in a short period of time.

So we pay a great deal of attention to that whole claims safeguard portion and, as I mentioned earlier, I think that is one area where perhaps intermediaries have performed better on average than ODR has.

Ms. MIKULSKI. Well, Mr. Bourque, just as you have indicated initiative for the DRG program came not from your intermediaries, came not from the providers, they came from the executive branch and Congress itself, that all innovations related to health care cost disciplines have emanated from the Government; they have not been emanating from the intermediaries.

Mr. BOURQUE. I agree. The DRG system did not come from the intermediaries.

Ms. MIKULSKI. Let's get it straight about who is saying bring this under some type of discipline.

The Reagan administration as well as the Carter administration stressed the need for competition in the health sector to control costs, a concept I am sure we have bipartisan agreement on. How do your plans to terminate ODR fit in with this philosophy stated by the Grace Commission that closing down ODR, a competitive element would be lost, would increase program costs and also eliminate the competition among intermediaries to reduce administrative costs?

Mr. **Bourque**. I have two points in response to that. First of all, I don't believe that ODR has served as a competitive element with our contractors. It is not in direct competition and we don't anticipate it would be in the future.

As far as competition between providers and contractors, frankly, we are discouraging that type of competition. We have a proposal before the Congress that seeks a greater authority to allow competitive bidding among our contractors in a particular area with a particular intermediary contract. We think that is appropriate because the contracting or competition would occur among intermediaries.

But we are not really trying to foster shopping for intermediaries on the part of providers because we think that the incentives for the providers to shop are not the right incentives. That is, providers may just want to go from one intermediary to another in order to get a better deal in terms of less claims review or less medical review. We don't think that is what we need.

What we need are contractors who are going to operate very efficiently and we need to foster greater competition among those contractors.

Mr. **Scott**. In addition, ma'am, we have a great deal of competition within the contracting community itself right now. It is not a big monolithic kind of organization. Whenever we look at a change in a contract structure or a coverage area, we find that our private contractors compete amongst themselves.

We have one chain agency that has talked to us voluntarily about leaving ODR and there are two private contractors, one representing the Blue Cross plan and one representing a commercial insurance company, that are competing very actively to see if they can secure that piece of business.

Ms. **Mikulski**. Mr. Bourque, I would agree that ODR is not in competition with the intermediaries. It was never meant to be.

But it is an example that comes under the direct administration and supervision of HCFA senior staff. Therefore, it should have been a model. If it is not a model, one needs to look then internally to the type of management that is going into ODR. And in terms of ODR, though maybe not in competition, background of the staff indicates that the ODR claims are substantially less than what the intermediary claims are for processing in areas of comparable claims, home health care, skilled nursing, and so on.

How do you account for that? It is $2 or $3 and we have heard range estimates that transferring this will cost anywhere from $5 to $7 in the process.

Mr. **Bourque**. The agency does keep statistics on the average cost per claim and it is true that in one of our recent reports we indicated that ODR when, compared on a unit cost basis with other intermediaries, ranked very low. But the unit cost per claim is not the only indicator of how well an intermediary functions.

For example, using that same ranking process to look at inpatient hospital claims processed within 30 days, ODR ranked 71st out of 76 intermediaries. For outpatient claims processed within 30 days, ODR ranked 66th out of 76 providers, and for skilled nursing facility claims processed in 30 days, 74th. And for another statistic, settling of a hospital cost report within 1 year, ODR ranked 70th.

So there are a lot of other things that we look at and monitor with our intermediaries that are important from the provider's standpoint, and important from our standpoint, that ODR has not been quite as sterling about.

I would add one other thing, and that is that in a way we are comparing apples and oranges because ODR's provider mix is very different from the provider mix of our intermediaries. It is servicing, out of 1,200 or so providers, 480 home health agencies. Whereas, if you go to the normal intermediary, the vast majority of the intermediary work is hospitals' inpatient claims and outpatient claims. It is very hard to say: "Hey, that unit cost per claim really means something," when you get behind that number.

Ms. Mikulski. Are you also saying that the intermediaries won't have the experience to process these because it has been in reimbursing hospitals and that this is a special expertise, reimbursing small-business providers?

Mr. Bourque. I think that issue was enjoined with the Congress in 1980. There was concern that spreading home health agency workload over every single intermediary was perhaps not the most efficient or effective way to do it. Congress directed us to regionalize the home health agencies.

We forced, if you will, or transferred home health agencies to regional intermediaries, of which there are now 46. That was in order to foster greater cost efficiencies and greater knowledge of the home health agency problem within an intermediary. We are going to piggyback on that.

Ms. Mikulski. I know.

Mr. Chairman, I have just two other questions.

To follow up on what you just said, ranking 70th and 71st there, isn't it because of the shortages of staff within ODR that while this whole issue of contracting out has been hanging around for a number of years, that, No. 1, your top people have left, that ODR, that once enjoyed a minimal staffing level of 300 is now down to 260, and that the kind of management supervision that means efficiency and productivity has been finished because of the uncertainty at ODR, the management uncertainties, the employment security instability, and that within that atmosphere nobody is productive because nobody is happy and because nobody knew what they were going to have and where they were going, and that that would be equally true in the private sector, and that that is one of the reasons that the data you furnished me has been based on the recent 12 months when productivity has been at an alltime low at ODR and HCFA generally?

Mr. Bourque. Well, it is true that the number of employees has diminished. And, frankly, that is one of the reasons why we are so concerned about our ongoing ability to keep ODR operating at full strength.

We do have other commitments in the agency and we need the kind of talent that ODR offers us in other areas. As I indicated earlier, we did detail by administrative direction 14 people back into ODR last spring in order to plug some of the holes that we saw because we were concerned about this. If we were to keep ODR we would obviously have a responsibility to keep it operating and doing an efficient job. We would be prepared to do that but that job is getting tougher and tougher.

We feel that since this is an area where the vast majority of our operations are in the private sector, we feel that it is a natural that we move this workload out.

Ms. MIKULSKI. Well, just to summarize that, you cannot say that ODR is more inefficient and lacks staff and at the same time have talked about dismantling it. In other words, it is like the chicken and the egg. They have talked about dismantling it. People have been moved down, moved around, and then efficiency drops and then you say we have got to contract it out, look how efficiency dropped.

Mr. BOURQUE. Some of the data provided to the committee does go back to 1980 and 1981. Even the recent data, as you point out, shows in some areas ODR remains efficient. So I am really not criticizing the job they have done. I think ODR has been a good intermediary for us.

Ms. MIKULSKI. Mr. Chairman, if you will, on last question.

You promised that all employees will retain their jobs at comparable levels and might be in line with certain promotions. As you know, I am particularly concerned about the minority women that work at HCFA. Many of them are the sole supporters of their families, went by all the rules and learned all the latest high tech and now might be out of that opportunity.

Do you have any written agreements that you have worked out with the employee organizations to protect these employees rather than verbal commitments?

Mr. BOURQUE. We have one agreement that we signed with the union back in early August having to do with the variety of skills, upgrading programs that we would offer our employees, and, in fact, some of the ODR employees have already joined those programs.

We also have just completed a strategy document on the placement program that we would utilize in ODR. We are prepared to negotiate that with the union. I know they have some concerns, obviously, that they want to sit down with us about.

We recently prepared that. We have not done so previous to this because we felt it would be flying in the face of rulemaking, that to begin to set up a placement program when we have yet to have the authority to do this would be premature.

On the other hand, we know that this has caused some anxiety and we would like to minimize that.

Ms. MIKULSKI. So you do not have any written agreements guaranteeing job security?

Mr. BOURQUE. We don't have a negotiated management union agreement yet, although we have a proposal that we will present to the union.

Ms. MIKULSKI. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. I have no questions.

Chairman JACOBS. Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

It is my understanding, sir, that HCFA justifies this program because it wants to bring about some consistencies within each State. At the same time, as a member of this committee, we have found that by singling out States, we have been able to get a better idea as to which procedures are more effective than others.

Do you care to comment on that?

Mr. **Bourque**. Yes; we feel that a part of the justification for this move is to build a caseload, if you will, for certain providers within each area. As I mentioned earlier, we do have regional intermediaries for home health agencies and we think that most of this workload will go to those regional intermediaries and establish that baseline for which we can go and analyze in a given area what is going on and also to continue to collect the national statistics.

Mr. **Rangel**. Did you testify already about whether or not you intend to transfer the automatic bill processing system to the intermediaries, the ones that you are using now?

Mr. **Bourque**. Yes; we are very concerned that our intermediaries be able to accept on the same basis that ODR accepts, either tape to tape or direct electronic processing and we are working with intermediaries to do that. Many of them already have that capability so there will be no additional investment involved.

Mr. **Rangel**. Could you assure this committee that this is going to be done and there would not be that additional cost?

Mr. **Bourque**. We will. I have stated to the home health community that we will not transfer agencies to intermediaries that cannot provide them this service.

Mr. **Rangel**. Is there a conflict with the effectiveness or at least the cost effectiveness between HCFA and the President's task force called the Grace commission as relates to the cost of this transition?

Mr. **Bourque**. We don't believe so, Congressman Rangel. The Grace commission did ask us to reconsider our analysis of this activity and we have had nearly 1 year since that proposal came out by the Grace commission to do that. In the meantime, of course, we have had the U.S. Court of Appeals establish our legislative authority to do that.

So we have, we think, addressed the concerns that the Grace commission was interested in.

Mr. **Rangel**. How far are you prepared to go to assure this committee that the rights of the employees will be protected besides this proposal that is not negotiated?

Mr. **Bourque**. I have stated personally to the employees as a group that we will guarantee them a job within the agency as we phase out ODR.

And by the way, I would add that the phaseout is not going to happen tomorrow or in November. We are talking about probably a minimum of 1 year to effectively and smoothly transfer this workload to other intermediaries.

So, as we move through this process, we will move the employees to other positions for which they are qualified, and where they are not, we intend to give them the kind of training that they need to move into these other jobs. So no one is going to be involuntarily put on the streets because of this.

Mr. RANGEL. And it would not inadvertently adversely affect their grade level?

Mr. BOURQUE. No. We will guarantee their grade levels and pays.

Mr. RANGEL. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Bourque, did the Grace commission criticize any other plans you have for phasing out any other operation?

Mr. BOURQUE. The Grace commission really focused more on where we could improve our efficiencies and deal better, for instance, with the contractor community. They would like us to do much more in the EDP area, electronic data processing, through our Bureau of Support Services.

Interestingly enough, while the Grace commission asked us to do a number of new things, they also recommended a 25-percent reduction in our staff. So we find it a little bit inconsistent to ask us to keep certain activities like ODR—or at least to have us reconsider phasing it out—at the same time they have asked us to look at effecting such employment savings.

So it is a little bit hard to read exactly where we should move on the basis of those recommendations. As I understand, they are still in draft form and have yet to be submitted to the president in final version.

Chairman JACOBS. I infer from what you say that the answer should be entered as, no, they did not recommend or criticize any other plans you have for phasing out any other operation?

Mr. BOURQUE. Not to my knowledge, sir.

Chairman JACOBS. That may seem significant on the record. That is the only area in which they criticized any plans to phase out an operation.

Mr. Bourque, you said that you would encourage intermediaries that do not already have electronic processing to adopt it. Can that be read as "require" and, if not, what is the definition of the gerund "encouraging"?

Mr. SCOTT. Mr. Jacobs, in our dealing with the intermediaries we have as one of our major objectives to increase the quantity of the claims we receive electronically. We found that not only does this help decrease the amount of money we have to pay nationally for claims payment, which is a little over $600 million, but also we think that in certain circumstances it is going to offer us some unique opportunities to improve the quality of our medical review activities and some of our other payment safeguards.

We have started an enormous effort within the agency to focus our regional offices and intermediaries on electronic billing. We are establishing specific annual growth for each intermediary to increase the number and percentage of claims that they receive electronically, and we are hoping by the end of this decade—and it is going to take us probably that long—that we will have 90 to 95 percent of all of our part A claims submitted electronically and dealt with in that mode.

So the initiative is a much broader initiative than simply the electronic billing issues that we see in conjunction with the ODR transfer.

Chairman JACOBS. The question is, What is the initiative? What is the goal? I have lots of goals that I never seem to achieve.

Mr. Bourque. Mr. Chairman, with respect to this particular phaseout, as Mr. Scott mentioned, we have a broader plan, but with respect to this particular phaseout, I think we would like to be able to require intermediaries to do this.

As I mentioned earlier, we are more apt to encourage intermediaries, but the safety valve of what we have here is that if they are unable in a reasonable amount of time to make the systems changes, we have told the providers that we won't transfer them. So the safeguard to the provider is that until that system is set up and until it is with an intermediary that you can relate to on the same basis you relate to ODR, we won't make the move.

Chairman Jacobs. The move from what?

Mr. Bourque. The move from ODR. We won't transfer that workload.

So I would not want to use "require."

Chairman Jacobs. As far as the providers are concerned, are you saying that it is a certainty that none would be required to deal with an intermediary that did not have electronic processing?

Mr. Bourque. If they are currently submitting electronic bills to ODR—and I might add, only 40 percent are—yes, we would guarantee that.

Chairman Jacobs. Thank you.

Are there any further questions?

Mr. Moore. Mr. Chairman?

Chairman Jacobs. Mr. Moore.

Mr. Moore. Mr. Chairman, may I make two comments and ask Mr. Bourque to comment, if he chooses to, on the correctness of these two comments first?

I think the gentlelady from Maryland made a good point about whether or not the intermediaries are competent to handle experienced home health care claims. I understood from Mr. Bourque's testimony that 86 percent of all home health care agencies are already using intermediaries. So it would seem to me that they have far more experience than probably ODR has if they only have 14 percent.

Second, the gentlelady made a comment that the DRG payment system came from the executive and legislative branch. As much as I would like to think we were the ones who dreamed that up and put it in legislative form, it is really not so.

That idea came as much from the industry and from people writing and thinking as it did from those of us in the Government. I don't want the impression to be left that those of us in Government were so bright that we dreamed that up all by ourselves. I don't think the gentlelady meant to do that.

It may well be if it does not work, we will be accused of that. But right now, we have to share whatever glory there is in that movement.

Thank you, Mr. Chairman.

Chairman Jacobs. We thank the administration for its time and articulate testimony.

The chair now recognizes Representative Mikulski for a statement.

STATEMENT OF HON. BARBARA A. MIKULSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Ms. Mikulski. Thank you, Mr. Chairman.

Of course this morning we are focusing on a bill that I introduced, H.R. 2481, otherwise known as the Medicare Fiscal Intermediary Amendment Act. My legislation is also cosponsored by colleagues like Congressman Ron Wyden, Congressman Claude Pepper, Congressman Clarence Long, and 37 others, and would amend the Social Security Act to retain the option of the direct reimbursement for health care providers under the Medicare Act.

Simply stated, my legislation would enable them to choose either to go to an intermediary or stay with ODR. HCFA has announced its intention to dismantle it and I believe that the argument for dismantling ODR is ill-advised and contrary to the best interest of the medicare program and to the taxpayers.

I feel this because it will add to the overall medicare costs, not only by significant transition costs but by additional long-term claims processing administrative costs. These costs will be increased because the existing cost effective electronic billing systems used by ODR will be dropped.

HCFA will lose its ability to monitor costs of its intermediary and set a standard of performance. In addition, we will lose the competitive alinement between ODR and the intermediaries that help insure quality of performance and cost efficiency. The termination of ODR will restrict HCFA's ability to experiment with innovative billing processes and also will lose its unique home health care data base, which is important.

I am not the only one, of course, who believes this. All of the members of the committee have referred to the Grace commission that recommended that ODR be retained.

This issue was first brought to my attention by HCFA employees who feared the loss of their jobs. HCFA is within the Third Congressional District in Baltimore, and being on the Waxman committee, it was a natural that we would discuss this.

I know that you have heard and you will hear from the concerns of the employees. When the employees came to me, they expressed a concern not only about their job security, but about the mission of ODR and what they felt was performing a very important job in controlling costs and meeting providers' needs simultaneously.

Mr. Chairman, I will not go through my entire statement, but I would also like to bring to the committee's attention that the dismantling of ODR runs counter to the wishes of Congress.

The 1980 Reconciliation Act, section 930(O) makes it very clear that medicare providers are to attain the choice of contracting directly either with the Federal Government or reimbursement by going to an intermediary or dealing directly with the Federal Government.

HCFA has chosen to ignore the intent of that 1980 Reconciliation Act. Medicare costs are rising. It will be other than just our major foreign policy considerations that we will be considering. I believe that the medicare program will be the big issue before the Congress in the coming months, and we must take all provable, positive steps to bring costs under discipline and use the valuable data base to come up with strategies that meet our implied contract with the taxpayers and our contract with the senior citizens.

I think this is the forerunner of issues to come. Thank you very much.

Chairman JACOBS. Mr. Russo?

Mr. RUSSO. I have no questions.

Chairman JACOBS. Mr. Duncan?

Mr. DUNCAN. No questions.

Chairman JACOBS. Mr. Rangel?

Mr. RANGEL. No questions, thank you, Mr. Chairman.

Chairman JACOBS. Our next witness, representing the American Federation of Government Employees, is Nicholas J. Nolan, accompanied by John Gage, president of the organization.

Mr. Nolan.

STATEMENT OF NICHOLAS J. NOLAN, NATIONAL SECRETARY-TREASURER, ON BEHALF OF KENNETH T. BLAYLOCK, PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, ACCOMPANIED BY JOHN GAGE, PRESIDENT, AFGE LOCAL 1923; AND JOE FLYNN AND PHIL OTTO, LOCAL OFFICERS

Mr. NOLAN. Mr. Chairman, my name is Nicholas Nolan, secretary-treasurer of the American Federation of Government Employees and I am here on behalf of Mr. Blaylock, and joining me today on my left are John Gage, who is the president of Local 1923, representing the employees of the Social Security Administration in Baltimore, and two officers of the local, Mr. Joe Flynn and Mr. Phil Otto, who are also HCFA employees.

The American Federation of Government Employees is pleased to have this opportunity to testify on the administration's proposed elimination of ODR. AFGE represents over 700,000 employees throughout the executive branch of Government.

The American Federation of Government Employees and organized labor are deeply concerned about the recent notice in the Federal Register concerning the Health Care Financing Administration's intention to dismantle its Office of Direct Reimbursement and contract out its function to the private sector.

At a time of significant cost increases for the purchase of health care services, which, as this committee recognizes, threaten the very existence of the medicare program, it is surprising that the Health Care Financing Agency would propose to do away with the office which has been the most efficient in processing claims.

We can find no legitimate justification for such an arbitrary and potentially far-reaching action. In fact, the recent survey on cost control performed by private business representatives for this administration concluded that the plan to do away with ODR would only increase program costs.

The evidence, in HCFA's Statistical Standards Report, Analysis of Intermediary and Carriers Administrative Cost, indicates that the Office of Direct Reimbursement has provided high-quality service at the lowest cost. Contracting out its responsibilities to private companies where the administrative costs of processing claims is two or three times higher make no sense at all.

It is the position of AFGE that contracting out ODR is unnecessary and will not save Government funds.

Unlike the administration's February 18, 1982, draft regulations, in its recent Notice of Proposed Rulemaking, HCFA has dropped any language attempting to show that this function could be done more effectively or for less cost in the private sector.

In an internal HCFA memo of March 3, 1983, Jim Williamson, Deputy Director of the Bureau of Support Services, stated:

> To convey the impression that removing the direct deal option is based on more effective and efficient administration of the medicare program is terribly misleading.

To date, the agency has not done a cost comparison study as required by Office of Management and Budget Circular A-76. Nor have they provided any cost comparison figures in the regulation to support their contention that it would be more cost-effective for the work of ODR to be done by the private sector.

The regulations actually indicate that there would be increased costs to the medicare program, in the form of significant transition costs for providers and long-term increases for intermediaries as a result of increased claims loads.

As a matter of fact, even the President's Private Sector Survey on Cost Control, the Grace commission, a group notorious for its anti-Federal employee attitude, states, in its report on the Department of Health and Human Services, that the plan to eliminate the Office of Direct Reimbursement "will actually increase cost—conservatively $1.2 million—rather than produce savings."

Moreover, HCFA has not prepared the regulatory impact analysis, as required by the Regulatory Flexibility Act, Public Law 96-354, to assess accurately the increased cost of contracting out ODR.

The regulations offer no evidence to support the assertion that these costs will be minor, and therefore do not require such a study, while at the same time acknowledging that "the magnitude of the effects of the proposed rules cannot be accurately predicted."

HCFA has also not prepared a regulatory flexibility analysis of the regulations, which assesses the impact of the rule on small businesses.

Again, no data is offered to verify the contention that "the impact on affected entities will not be significant," although the regulations do recognize that nearly 10 percent of all medicare providers—some 1,200 health care organizations—will be affected by these proposals.

In both cases, HCFA has not provided information to justify the conclusions that the cost to the medicare program or the effect on health care providers will not be major.

The regulations also misstate congressional intent regarding the improved administration of the home health care program under medicare as contained in the 1980 Omnibus Budget Reconciliation Act.

The language in the 1980 conference report on the 1980 Reconciliation Act is clear:

> In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that the home health agencies would be precluded from contracting directly with the Health Care Financing Administration.

These proposed regulations therefore clearly serve to undermine, rather than implement, the intent of Congress with respect to direct Federal reimbursement of medicare claims.

The Office of Direct Reimbursement has proven to be a cost-effective mechanism for controlling rising medicare claims processing expenses. According to HCFA's own figures from its Statistical Standards Report, ODR had the second lowest processing cost nationwide of 66 intermediaries in fiscal year 1982.

In the most recent quarterly report, for the second quarter of fiscal year 1983, the ODR had the absolute lowest processing costs.

In addition, ODR is a leader in cost avoidance and the recoupment of medicare funds for the Government, through audits and medical reviews, with a ratio of savings realized to administrative costs incurred far higher than that of the private sector.

ODR enjoys a national reputation for its promptness in processing claims, consistent and fair application of standards in judging medicare services, and expertise in all areas of health care.

This record has been achieved in spite of a severe reduction in ODR personnel, and a complicated claims load. The success of the Office of Direct Reimbursement is underscored by the lengthy list of providers waiting to contract with ODR for direct reimbursement.

The rationale for the administration's actions seem to stem from two sources. The first is to avoid budgetary and personnel ceilings within Health and Human Services. The administration appears to be willing to put an even greater financial strain on the beleaguered medicare trust fund to hide budgetary and personnel costs.

As the previously cited March 3 memo states, "Discussions to eliminate the direct deal activity have always been based on budget and staffing considerations."

The second reason comes from the administration's view that anything that the private sector can do, regardless of the cost to American taxpayers, should be done by the private sector.

This orientation has been evident in this administration's actions from the start, and, in particular, in this administration's actions toward ODR. It has discouraged any new providers from seeking the services of ODR and has, in the opinion of AFGE local leaders, encouraged providers currently being serviced by ODR to leave the system.

Although the proposal to eliminate the ODR is consistent with the administration's philosophy, it is not consistent with the needs of providers, the financial stability of the medicare system, or the interests of the American taxpayer.

ODR's cost-effectiveness and efficiency, the vital claims processing and evaluation capabilities it provides for the Federal Government, and the lack of any compelling reasons for contracting out its functions to the private sector forcefully argue against the implementation of these proposed regulations.

We have also attached the comments of AFGE Local No. 1923, which represents the HCFA employees, on the administration's proposal.

I urge this committee to work for the enactment of H.R. 2841, introduced by Barbara Mikulski, which would preserve this important office in the medicare program.

[The prepared statement of Kenneth Blaylock and the information referred to follows:]

STATEMENT OF KENNETH T. BLAYLOCK, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

The American Federation of Government Employees [AFGE], AFL-CIO, is pleased to have this opportunity to testify on the Administration's proposed elimination of the Office of Direct Reimbursement [ODR] at the Health Care Financing Administration [HCFA]. AFGE represents over 700,000 employees throughout the executive branch of government.

The American Federation of Government Employees and organized labor are deeply concerned about the recent notice in the Federal Register concerning the Health Care Financing Administration's intention to dismantle its Office of Direct Reimbursement [ODR] and contract out its functions to the private sector.

At a time of significant cost increases for the purchase of health care services, which, as the committee recognizes, threaten the very existence of the medicare program, it is surprising that the Health Care Financing Agency would propose to do away with the office which has been the most efficient in processing claims. We can find no legitimate justification for such an arbitrary and potentially far reaching action. In fact, the recent survey on cost control performed by private business representatives for this Administration concluded that the plan to do away with ODR would only increase program costs.

The evidence, in HCFA's Statistical Standards Report, Analysis of Intermediary and Carriers Administrative Cost, indicates that the Office of Direct Reimbursement has provided high quality service at the lowest cost. Contracting-out its responsibilities to private companies where the administrative costs of processing claims is two to three times higher make no sense at all.

It is the position of AFGE that contracting-out ODR is unnecessary and will not save Government funds.

Unlike the administration's February 18, 1982 draft regulations, in its recent Notice of Proposed Rulemaking, HCFA has dropped any language attempting to show that this function could be done more effectively or for less cost in the private sector. (In an internal HCFA memo of March 3, 1983, Jim Williamson, Deputy Director of the Bureau of Support Services stated ". . . to convey the impression that removing the direct deal option is based on more effective and efficient administration of the Medicare program is terribly misleading.")

To date, the Agency has not done a cost comparison study as required by Office of Management and Budget Circular A-76. Nor have they provided any cost comparison figures in the regulation to support their contention that it would be more cost-effective for the work of ODR to be done by the private sector. The regulations actually indicate that there would be increased costs to the medicare program, in the form of significant transition costs for providers and long-term increases for intermediaries as a result of increased claims loads.

As a matter of fact, even the President's Private Sector Survey on Cost Control (the Grace Commission), a group notorious for its anti-Federal employee attitude, states, in its report on the Department of Health and Human Services, that the plan to eliminate the Office of Direct Reimbursement "will actually increase cost, (conservatively $1.2 million) rather than produce savings."

Moreover, HCFA has not prepared the regulatory impact analysis, as required by the Regulatory Flexibility Act (Public Law 96-354), to assess accurately the increased cost of contracting-out ODR. The regulations offer no evidence to support the assertion that these costs will be minor, and therefore do not require such a study, while at the same time acknowledging that "the magnitude of the effects of the proposed rules cannot be accurately predicted." HCFA has also not prepared a regulatory flexibility analysis of the regulations, which assesses the impact of the rule on small businesses. Again, no data is offered to verify the contention that "the impact on affected entities will not be significant", although the regulations do recognize that nearly 10 percent of all medicare providers—some 1,200 health care organizations—will be affected by these proposals. In both cases, HCFA has not provided information to justify the conclusions that the cost to the medicare program or the effect on health care providers will not be major.

The regulations also misstate congressional intent regarding the improved administration of the home health care program under medicare as contained in the 1980 Omnibus Budget Reconciliation Act. The language in the 1980 Conference Report on the 1980 Reconciliation Act is clear: "In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that the home health agencies would be precluded from contracting directly with the Health Care Financing Administration." These proposed regulations therefore clearly serve to undermine, rather than implement, the intent of Congress with respect to direct Federal reimbursement of medicare claims.

The Office of Direct Reimbursement has proven to be a cost-effective mechanism for controlling rising medicare claims processing expenses. According to HCFA's own figures from its Statistical Standards Report, ODR had the second lowest processing cost nationwide of 66 intermediaries in fiscal year 1982. In the most recent quarterly report, for the second quarter of fiscal year 1983, the ODR had the absolute lowest processing costs.

In addition, ODR is a leader in cost avoidance and the recoupment of medicare funds for the government, through audits and medical reviews, with a ratio of savings realized to administrative costs incurred far higher than that of the private sector. ODR enjoys a national reputation for its promptness in processing claims, consistent and fair application of standards in judging medicare services, and expertise in all areas of health care. This record has been achieved in spite of a severe reeducation in ODR personnel, and a complicated claims load. The success of the Office of Direct Reimbursement is underscored by the lengthy list of providers waiting to contract with ODR for direct reimbursement.

The rationale for the administration's actions seem to stem from two sources. The first is to avoid budgetary and personnel ceilings within Health and Human Services. The administration appears to be willing to put an even greater financial strain on the beleaguered Medicare Trust Fund to hide budgetary and personnel costs. As the previously cited March 3 memo states, "Discussions to eliminate the direct deal activity have always been based on budget and staffing considerations."

The second reason comes from the administration's view that anything that the private sector can do—regardless of the cost to American taxpayers—should be done by the private sector. This orientation has been evident in this administration's actions from the start and, in particular, in this administration's actions toward ODR. It has discouraged any new providers from seeking the services of ODR and has, in the opinion of AFGE local leaders, encouraged providers currently being serviced by ODR to leave ODR. Although the proposal to eliminate the ODR is consistent with the administration's philosophy, it is not consistent with the needs of providers, the financial stability of the medicare system, or the interests of the American taxpayer.

ODR's cost effectiveness and efficiency, the vital claims processing and evaluation capabilities it provides for the Federal Government, and the lack of any compelling reasons for contracting-out its functions to the private sector forcefully argue against the implementation of these proposed regulations.

We have also attached the comments of AFGE Local 1923, which represents the HCFA employees, on the administration's proposal.

I urge this committee to work for the enactment of H.R. 2841, introduced by Barbara Mikulski (D. Md.), which would preserve this important office in the medicare program.

American Federation of Government Employees AFL-CIO,
Baltimore, Md., August 18, 1983.

Carolyne K. Davis, Ph. D.
Administrator, Health Care Financing Administration,
Baltimore, Md.

Dear Dr. Davis: The following are our comments on your Notice of Proposed Rulemaking: Medicare Program; Reduction in the Number of Providers and Health Maintenance Organizations Dealing Directly With HCFA—BPO-28-P-42 CFR Parts 405 and 421.

THE LACK OF LEGAL AUTHORITY

The proposed regulation's intent to contract out the Office of Direct Reimbursement clearly runs counter to the intent of Congress, as expressed in the 1980 Omnibus Budget Reconciliation Act, Pub. L. No. 96-499, Section 930(o), 94 Stat. 2599, 2632 (1980) (codified at 42 U.S.C. Section 1395(h)(e)(4) (Supp. 1980)). Section 930(o) makes clear that Medicare providers are to retain the choice of contracting directly with the Federal Government for reimbursement. This amendment did not require the Secretary to assign all freestanding Home Health Agencies to regional intermediaries. The amendment only required the Secretary to designate which intermediary a Home Health Agency would use if the Home Health Agency elected to use one at all. The House conferees were careful to point out that "in requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration."[1]

THE LACK OF A RIGOROUS COST ANALYSIS

The text of the supplementary information at 48 FR 34979 that "The decision to use the Secretary's authority to contract out the responsibility for servicing providers is based on considerations that indicate that this would result in the more effective and efficient administration of the Medicare program."

The proposed regulations provides no supporting facts or figures to support this conjecture. There has been no cost comparison study done to demonstrate that the work performed by the Office of Direct Reimbursement could be done more cheaply in the private sector. In point of fact, since HCFA will continue to pay the full salaries and expenses for all Office of Direct Reimbursement employees at the same time that it is incurring the contractual expenses for processing over 3 million claims per year, there is no way that this proposed contracting out will not end up doubling the costs for processing these claims. The Agency action is violative of OMB Circular A-76, in whole or in part.

VIOLATION OF REGULATORY FLEXIBILITY ACT

The Regulatory Flexibility Act (Pub. L. 96-354) requires the Agency to prepare and make available to the public a regulatory flexibility analysis where a proposed regulation would have a significant impact on a substantial number of small entities. The proposed regulation would have a significant impact on the following providers of services, all of whom fit the definition of a small entity: Hospitals, 220; skilled nursing facilities, 60; hospital-affiliated and freestanding HHA's, 465; providers of physical therapy services, 21; end-stage renal disease facilities, 7; health maintenance organizations, 70; Federal hospitals, 377.

The United States Court of Appeals for the District of Columbia, in its decision in National Association of Home Health Agencies v. Schweiker, found at page 35, "Furthermore, the elimination of this right will cause freestanding HHA's great expense and inconvenience. Appelleas presented uncontradicted evidence that the transfer will cost an estimated $10 million to $30 million. Many HHA's will be required to change or scrap electronic billing systems which have been designed to interface with equipment used by the Secretary. Numerous HHA's will be required to train and re-educate employees to implement the new system and operate with the guide lines of the new intermediary."

It is inconceivable that the Court found this much of an impact on just Home Health Agencies alone and you find no significant impact on a far wider range and number of providers.

In summary, we find your Notice of Proposed Rulemaking to be violative of the 1980 Omnibus Budget Reconciliation Act, OMB Circular A-76, and the Regulatory Flexibility Act.

Sincerely,

JOHN GAGE,
President, Local 1923.

Chairman JACOBS. Nine minutes, 16 seconds.

Mr. Moore?

Mr. MOORE. I understand one of the costs to be incurred during the phasing out of ODR is the fact that HHS or HCFA agreed to pay the full salary at current levels for all of the people currently working for ODR. So essentially you have a double payment being made by HCFA—one to the intermediary and one in the form of salaries to the employees of ODR while it is being phased out, and employees are being moved into new positions.

I assume that you are in favor of this situation of paying the employees at the ODR their full salaries?

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[1] H. Conf. Rept. No. 1479, 96th Congress, 2d Session 129 (1980).

Mr. NOLAN. Mr. Moore, we have a very unique role in the labor movement in that we represent the employees of the Federal Government, who are, in turn, representing the American taxpayers.

We have always maintained a philosophy in our union of a broader issue than the merits of employees on the day-to-day basis, and we have tried to be a very vigilant watchdog of the rights of the American taxpayer, and part of our concern in this case is not only for the 300 ODR employees, but it is also what is good for the American public.

Your question puts us in a very difficult position, because we certainly do want to maintain the cost, the nature of the protection for these employees, but we are not interested in increasing the cost to the taxpayer at the same time.

Mr. MOORE. Well, I appreciate the work that your union has done, and I appreciate the tenderness of the answer you gave, but we really have the administration on a fence that we love to knock them off of, and if they don't look after the employees, people come in and rail we are not looking after them, and if we do, they rail that you are paying them double.

I would assume you would come down on behalf of the dues-paying employees, and say this was the right thing to do.

Mr. NOLAN. The bottom line, sir, we certainly would.

Mr. MOORE. One other question. You have commented on how good ODR has been, and you heard the testimony of Mr. Bourque, and other reports they have not done that good. We will have to take a look at this and resolve it, but there is some evidence to the contrary about how efficient they have been.

One thing that worries me about all of the people that want to use ODR, I wonder if they want ODR because they are better, or because there is less chance of an audit, and there is a better chance they are going to get the bill through.

That is something we have to consider for the taxpayer.

Mr. NOLAN. Mr. Otto deals with these people on a day-to-day basis.

Mr. OTTO. The idea that a provider would turn to the HCFA to have an easier deal kind of flies in the face of reality, that a provider's history follows them wherever they go. That history is turned over to ODR and ODR performs the contract annual audits of every provider they have, and they have the capability of doing the accounting and auditing and the medical review with the nursing staff just like any private intermediary does.

There was a recent report which was rather praiseworthy of the work of ODR, recommending strongly that HCFA pursue the guidelines that ODR uses.

Mr. MOORE. Looking at the number of audits being run, we know in any field, if you have a low risk of being audited, sometimes people get a little freer with the reports they send in. That is something we have to consider from the taxpayer's point of view.

If anybody comes to the Federal Government to handle something for them, they are making a real mistake in the long run. One reason why they came was because of the ODR's electronic billing system. It is faster and we hope nobody will be forced to take a step back in time in this regard. The administration has assured this in their testimony.

The auditing procedure, auditing anything, whether it is income tax returns or anything else, I heard the gentlemen from New York make that comment many, many times to the embarrassment of the Reagan administration, more than pays for itself, and that is not being done adequately right now at ODR.

Mr. OTTO. The ratio for return is for every dollar invested, the recoup 12. If you cut down on the number of accountants, you will cut down on the number of audits, it is just that simple.

Mr. MOORE. Thank you, gentleman, for answering my questions.

Chairman JACOBS. Ms. Mikulski?

Ms. MIKULSKI. In your comments, you indicated that the contracting out of ODR will significantly increase costs, both transitionally and in terms of long-term processing. Would you care to elaborate on that, how much will it increase costs and is it worth being concerned about?

You heard the administration's testimony that it was going to be minor and insignificant within the framework of the overall budget.

Mr. OTTO. Well, the evidence that was presented by the providers themselves indicates that, and the administrative cost area could rise as high as $30 million. The agency cannot predict this, and neither can we, unless they do some kind of a cost study and do some comparison analysis.

If you leave out the cost of continuing to pay for the salaries and expenses of the employees, that kind of a rigorous analysis has never been done, and I can speculate, the providers can, HCFA can speculate, but nobody knows, and that is why it is so important that this kind of a rigorous analysis be done.

We do know that the court accepted the providers' figure of costs ranging up to $30 million. That was undisputed by the administration.

Ms. MIKULSKI. Well, you are saying that no cost study was done, and therefore, the impact——

Mr. OTTO. No valid cost study was ever done. The administration at one time asked the Inspector General to do a cost study, but that was later so widely criticized that they abandoned it.

Ms. MIKULSKI. I see.

Well, then, if there has been no cost study, no regulatory impact, the statement made on small business, what do you think then is the point of dismantling and contracting out ODR if it will not save money?

What do you think is the thrust to do it?

Mr. OTTO. It is twofold. It is easier for the administration to deal with the increased costs if they transfer those costs over to the medicare contractor budget. Those costs are more hidden than the salaries and expense figures are, and also a question of the personnel ceiling, which the agency has been fighting about with OMB for over 2 years.

If you are committed to reducing the size of Government, you don't want to see ODR grow, and that will happen. There is no absolute ceiling to ODR. It is somewhat controllable, but it is a free choice for a provider to come in and request to be reimbursed by ODR, and if they are, the administration has to meet that responsibility, so there is potential here for staff increases.

That is the absolutely last thing that they want to see.

Ms. MIKULSKI. One final question, Mr. Bourque has said assurances have been made to the ODR employees concerning their employment and training opportunities. What is your view of these assurances?

Mr. NOLAN. Mr. Flynn?

Mr. FLYNN. First of all, I really believe Mr. Bourque is an honorable man, and I believe that the commitments he gave concerning the employees were made sincerely. From my vantage point, however, I really have some doubts as to whether that commitment can be lived up to.

First of all, we have attempted to negotiate through the bargaining processes an agreement which would put in writing and give legal status to these commitments. So far, we have not been able to reach agreement.

There was approximately four to five negotiating sessions, and for the last 2 months, we have not heard anything further from the administration.

The second thing is that the discussions around the agreement have centered on how we are going to insure that nobody loses a job because of dismantling ODR, but nothing has been said about after it is dismantled, whether the employees, you know, because of staffing limitations and so forth in the future, are going to be subject to any adverse impact.

And our third concern is that ODR employees are good employees, and I don't think they could be beat.

The problem is, they are in a unique occupational series, that in the main, their skills are not transferable to other occupations in our Agency, and while we have the administration saying that we are going to have training programs and so forth, I have yet to have anything saying that qualification requirements for getting into these other jobs are going to be waived, what the extent of training is going to be other than, you know, very broad terms we have talked about.

And I am very concerned that maybe there are a lot of these employees who are good employees, who have been in the job 15, 20 years. Are you really going to be able to take them and put them into some of these other occupations? That is a big question, and that concerns me.

Ms. MIKULSKI. What is the profile of ODR? Isn't it accountants and computer people?

Mr. FLYNN. Yes, I think the higher graded employees, accountants, nurses, they will not have any problem if the office should be dismantled in securing other jobs within the agency, but it is a twofold structure in ODR.

You have very high-graded professional employees and at the other end, it is the lower graded clerical, primarily women, minorities, basically claims technicians, clerks, performing jobs that are very unique to the ODR operation.

My concern lies with that last group, and they make up a good percentage of the ODR work force, and I just cannot imagine—they have said, well, we are going to have computer training courses, and a lot of the lower graded people are going to get into that.

You take a 55-year-old lady who has been in the job 25 years doing claims processing, and to say you will put her into a high-speed computer training program and make a program analyst out of her, I have some questions about that.

My concern is, what happens after the place is dismantled? What happens when they get into the training program and can't cut it? Where do they go then?

Ms. **Mikulski.** Thank you. That answers my question.

Chairman **Jacobs.** Mr. Otto, a moment ago, when you discussed the philosophy of the administration, you said it was consistent, their philosophy and reducing the size of the Government.

You meant numbers of employees and not expenditures of the Government?

Mr. **Otto.** That is right.

Chairman **Jacobs.** We have a panel made up of the National Association of Home Cáre, Grant Howarth, Washington Association of Home Health Agencies; Home Health Services and Staffing Association, Kenneth Healy, director of medicare, Medical Personnel Pool of America; and American Federation of Home Health Agencies, Inc., William S. Turf, administrator, Professional Home Health Care.

I remind you that it is requested by the committee that you make your statement in 5 minutes.

Please proceed.

STATEMENT OF GRANT C. HOWARTH, PRESIDENT, WASHINGTON ASSOCIATION OF HOME HEALTH AGENCIES, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Mr. **Howarth.** My name is Grant C. Howarth. I am the president of the Washington Association of Home Health Agencies and comptroller of the Seattle-King County Visiting Nurse Services.

I am representing the National Association for Home Care, the Nation's largest organization representing home care providers and individual home care professionals and paraprofessionals.

NAHC's nearly 1,500 members include large and small home health agencies, free-standing, hospital and nursing home-based agencies, visiting nurse associations, major corporate chains, homemaker/home health aide agencies, and hospices.

I am very pleased to have the opportunity to present NAHC's views on the Administration's proposed elimination of the Office of Direct Reimbursement at the Health Care Financing Administration. We believe that the continuation of the existence of ODR is both in the public interest and in the interest of the efficient administration of the medicare program.

We want to be clear at the outset that we are not arguing for ODR's preservation because ODR is more liberal in its interpretation of regulations and payment of claims. ODR has been very tough on our member providers.

In recent months, we have received substantial correspondence from members regarding ODR's issuance of proportionately greater denials and intensive medical reviews.

There has been testimony given already about the high audits at ODR. We would be happy to provide some letters with regard to this.

Even though ODR has been tough on our members, we have been consistent in our position that it is critical to preserve ODR. We felt so strongly that when HCFA illegally attempted to abolish ODR in 1981, we went to court and blocked it, forcing HCFA to issue regulations and follow the Administrative Procedures Act.

We feel ODR must be preserved for several reasons.

One, consistent application of regulations and familiarity with home health issues and regulations.

ODR has a long track record and has been in the business since the inception of the medicare program. It has been used by the Government to track all section 222 and other demonstration projects.

It is conversant with issues and regulations associated with home health care, its innovations and the industry. This is not the case with newly designated statewide intermediaries who are primarily Blue Cross and trained in hospital matters. They in fact do not have the same familiarity with home health care as does ODR.

Because of ODR's familiarity and experience with home health issues, it has been consistent in its application of regulations.

This is critical to our membership. Varying and inconsistent interpretations of regulations by fiscal intermediaries has been a serious problem. It causes loss to the medicare fund as well as to other providers.

A prime example of this is the multiple and conflicting interpretations of "intermittent care," a basic issue in home health.

Other intermediaries have done this, but in fact, ODR has avoided these problems. Congressman Waxman has introduced legislation because of these problems, H.R. 3616, to correct them.

We would like to clear up as a second argument some discussion concerning claims processing. It has been stated here the guarantee that providers would not be shifted, but that, in fact, automated claims processing would be provided for individual providers.

The fact is that we are not looking at just claims processing as the automated capability. Most providers have that capability, but there is the automated eligibility inquiry, the automated eligibility response, automated service coverage determinations and the automated claims processing and the automated billing processes.

We need to talk about all of those processes, if we are looking for a guarantee to support the home health agencies so they don't take a step backward. The losses to our agency as an individual agency who serves over 6,000 patients and makes over 130,000 visits is in the area of hundreds of thousands of dollars; not $5,000 to convert, but in the area of $60,000 to $80,000 to convert.

ODR is efficient and has the second lowest in claims processing costs. In a range of $2.28 to $4.88 to process each claim, ODR's cost comes in at only $2.73 per claim.

This certainly is in conformance with the good performance that has been encouraged in Public Law 95-142, which required the looking at the administration of and the effectiveness of the claims processing.

The Private Sector Task Force on Cost Control has also already been mentioned. We believe that the abolition of ODR will eliminate competition.

Of the 46 or 47 regional intermediaries, at least 82 percent are Blue Cross and Blue Shield. The existence of ODR and, therefore, a provider choice to deal with the Government directly, will provide incentives for responsiveness to providers, competition, and cut down costs and provide whatever is necessary in terms of competition to support home health agencies.

The elimination of ODR would do nothing but extend the concentration of already existing, virtual monopoly in each one of the regions.

It has already been discussed that the dismantling of ODR will increase costs. In September 1982, the U.S. Court of Appeals, District of Columbia Circuit, found there was "uncontradicted evidence that the transfer—of all ODR function to private contracted intermediaries—will cost an estimated $10 million to $30 million." We believe this is a gross understatement.

It does not include similar costs to other non-HHA ODR providers; that is, 220 hospitals, 60 SNF's, 70 HMO's.

Chairman JACOBS. Could you conclude directly?

Mr. HOWARTH. I will conclude directly and summarize the rest.

We recognize that the arguments are inconsistent that have been provided by HCFA. We vehemently oppose the elimination of the Office of Direct Reimbursement. There is overwhelming evidence that the abolition of ODR will create additional funding costs and administrative costs.

Congresswoman Mikulski has introduced H.R. 2841, which would preserve ODR, and S. 1419 was introduced by Senator Paul Sarbanes, a parallel bill.

We strongly support these bills and any measures which would insure the continuation of ODR and do that soon. I would be happy to answer any questions you might have.

[The prepared statement follows:]

STATEMENT OF GRANT C. HOWARTH, PRESIDENT, WASHINGTON ASSOCIATION OF HOME HEALTH AGENCIES, COMPTROLLER, SEATTLE-KING COUNTY VISITING NURSE SERVICES, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

Mr. Chairman and members of the committee: My name is Grant C. Howarth. I am the President of the Washington Association of Home Health Agencies and Comptroller of the Seattle-King County Visiting Nurse Services. I am representing the National Association for Home Care [NAHC], the nation's largest organization representing home care providers and individual home care professionals and paraprofessionals. NAHC's nearly 1,500 members include large and small home health agencies, free-standing, hospital and nursing home-based agencies, Visiting Nurse Associations, major corporate chains, homemaker/home health aide agencies, and hospices.

I'm very pleased to have the opportunity to present NAHC's views on the Administration's proposed elimination of the Office of Direct Reimbursement [ODR] at the Health Care Financing Administration [HCFA]. We believe that the continuation of the existence of ODR is both in the public interest and in the interest of the efficient administration of the Medicare program. We want to be clear at the outset that we are not arguing for ODR's preservation because ODR is more liberal in its interpretation of regulations and payment of claims. ODR has been very tough on our member providers. In recent months, we have received substantial coorespondence from members regarding ODR's issuance of proportionately greater denials and intensive medical reviews. We would be happy to provide some of these letters for the record. We even filed a Freedom of Information Act request with HCFA seeking to service parameters used to screen plans of treatment. This request was turned down.

Even though ODR has been tough on our members, we have been consistent in our position that it is critical to preserve ODR. We felt so strongly that when HCFA illegally attempted to abolish ODR in 1981, we went to court and blocked it, forcing HCFA to issue regulations and follow the Administrative Procedures Act. We feel ODR must be preserved for several reasons.

1. CONSISTENT APPLICATION OF REGULATIONS AND FAMILIARITY WITH HOME HEALTH ISSUES AND REGULATIONS

ODR has a long track record. It has been in business since the inception of the Medicare program. It has been used by the Government to track all section 222 and other demonstration projects. As such, it is conversant with issues and regulations regarding home health care and intimately familiar with innovations and trends in the field. This is not the case with new designated statewide intermediaries, who are primarily Blue Cross and trained in hospital matters with little, if any familiarity with home health.

Because of its familiarity and experience with home health issues, ODR has been consistent in its application of the regulations. This is crucial to our membership. Varying and inconsistent interpretations of regulations by fiscal intermediaries (FIs) has been a serious problem resulting in confusion, disruption of business and monetary losses. ODR's consistency in its interpretations has avoided many of these problems.

A prime example of this is the multiple and inconsistent interpretations of "intermittent care" by other FIs. The problem has become so severe that Congressman Waxman has introduced legislation (H.R. 3616) to correct it.

2. CLAIMS PROCESSING CAPABILITIES

ODR has a highly efficient, sophisticated and cost-effective computer system and claims processing capability. Turn-around time for processing claims is reasonably quick and therefore helps cash flow for providers. Many home health agencies specifically purchased computer equipment to interface with ODR's system. Especially for these providers, abolishing ODR will cause significant down time, major disruption of services, and significant costs to shift to other intermediaries.

3. ODR EFFICIENCY

According to HCFA's own data, out of 74 intermediaries used to process and pay Medicare claims nationwide in fiscal year 1982, ODR was second in terms of efficiency expressed in the second lowest adjusted cost per claim. In other words, it costs the 74 intermediaries anywhere from $2.28 to $4.86 to process each claim. ODR was second lowest in cost to the government with average costs of $2.73 per claim. It is this type of good performance which was encouraged and desired under Pub. L. 95-142.

President Reagan's own Private Sector Task Force on Cost Control, in recommending retention of ODR, stated that dismantling ODR "will remove any element of competition in serving claims . . . and will actually increase the cost (of the Medicare program) rather than produce savings."

4. ODR ABOLITION WILL ELIMINATE COMPETITION

Of the 51 existing regional intermediaries for home health, at least 82 percent (42 FI's) are Blue Cross/Blue Shield. With the existence of ODR and the provider's choice of deal with the government directly, other FI's had incentives to be responsive to providers, to be efficient, to keep costs down, and provide services. Elimination of ODR would only extend the concentration of an already existing virtual monopoly. It would decrease competition among FI's by eliminating the second most efficient FI and elimination of data and performance base by which to evaluate the other FI's.

5. DISMANTLING ODR WILL INCREASE RATHER THAN DECREASE COSTS

There are varying estimates as to what the costs would be if ODR were eliminated. In September 1982, the U.S. Court of Appeals (District of Columbia Circuit) found there was "uncontradicted evidence that the transfer (of all ODR function to private contracted intermediaries) will cost an estimated $10 million to $30 million." We believe this is a gross understatement.

It does not include similar costs to other non-HHA ODR providers (i.e., 220 hospitals, 60 SNF's, 70 HMO's, 377 Federal hospitals, 21 agencies providing physical therapy, and 7 ESRD facilities), and it does not include the added costs in Medicare HHA visit costs which will result from the added billing costs. We agree with President Reagan's Private Sector Task Force on Cost Control, headed by J. Peter Grace, that the plan to eliminate ODR would increase cost rather than produce savings. This Task Force estimated a "conservative" cost increase of $1.2 million.

Ironically, the dislocation costs resulting from the elimination of ODR would be passed on to the Medicare program. Furthermore, this increase in costs would not be a one-time event, but rather, would be continuous over future years. Such continuous costs would include: (a) those resulting from the lack of competition and incentives for FI's; (b) those incurred in adapting computer systems originally designed to interface with ODR's system; (c) those resulting from inefficiency on the part of FI's to process claims; and (d) those resulting from the use of manual rather than computerized processing systems. The further irony is that these costs will be incurred at a time when the Medicare Trust Fund is already in a precarious position.

6. ODR PROVIDES IMPORTANT IN-HOUSE EVALUATION CAPABILITIES

In addition to anti-competitive and cost-effectiveness considerations, there are compelling reasons why the government should not be totally reliant on private insurance to process and pay claims. There is a critical need for an in-house claims processing capability, for only with such a capability can the government test and evaluate claims with ragard to costs per claim, administrative costs, and efficiency. ODR provides an impartial laboratory which allows the government to test new ideas and concepts, instead of going to the private health insurance industry, which has a vested interest.

Closing down ODR would abolish the most comprehensive and accurate home health data base we have—a data base which is now used to measure the performance of other contracted FI's. ODR has accumulated the data base over a long period of time as a result of dealing with providers and tracking demonstration projects. There is nothing more current in the way of statistics elsewhere in HCFA. It would be a major tragedy from both a statistical and tracking point of view to close down ODR.

As an example of the type of function that ODR can and should serve by way of maintaining a data base consider the soon-to-be effective hospice program. ODR served the intermediary for the hospice demonstration programs. ODR could be utilized as FI for all hospice programs so as to ensure a standard, measurable policy for evaluation purposes at the end of 3 years. It would be most valuable to have centralized national data collectd by ODR, rather than fragmented reports from different intermediaries from all over the country on this important new program.

7. HCFA'S QUESTIONABLE AND INCONSISTENT REASONS FOR ELIMINATING ODR

We are unable to identify even one plausible reason for closing down ODR. Since HCFA embarked on this course in 1981, it has given contradictory and conflicting reasons for pursuing this action.

(a) Cost-cutting

At one point, HCFA claimed that its reasons for eliminating ODR were budget-driven. Getting rid of ODR would allegedly result in a reduction of employees and reduction in costs to the Government.

NAHC's Response.—By now, so many employees have already left ODR that any dollar savings that might result from a reduction in personnel or in case-load, by refusal to take on new providers, would already have been achieved. As to the argument that eliminating ODR would cut costs, as stated before, such action will increase rather than cut costs.

(b) Need to increase competition

HCFA has argued that eliminating ODR will increase competition.

NAHC response.—President Reagan's Private Sector Task Force on Cost Control has said that eliminating ODR will be anti-competitive.

(c) Need to increase efficiency of the medicare program

HCFA has argued that eliminating ODR would increase the efficiency of the Medicare program.

NAHC response.—According to HCFA's own data, ODR is the second most efficient FI in claims processing out of 74 FI's.

(d) 1981 Medicare amendment required HCFA to eliminate ODR

It has also been argued that the 1981 Amendments giving HHS the authority to establish designated statewide intermediaries gave HHS the authority to eliminate ODR.

NAHC response.—As Chairman Jacobs accurately stated in a December 11, 1981 letter to Congressman Andy Ireland:

"In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration."

The U.S. Court of Appeals (District of Columbia) supported Congressman Jacobs' view in its 1982 decision in our lawsuit.

(e) Private industry can perform the function as well as Government

Finally, HCFA has contended that the government should not be involved in activities which private industry could perform as well.

NAHC response. —This argument is tantamount to saying that HCFA wants to give monopolistic control of the claims payment function to the insurance industry. As we have noted, there are compelling public policy reasons why this shouldn't be done. In addition, HCFA's own Fiscal Intermediary evaluation data shows ODR is more efficient than all but one of the private intermediaries.

CONCLUSION

We vehemently oppose the elimination of the Office of Direct Reimbursement. There is overwhelming evidence that the abolition of ODR would create additional administrative and funding costs to the Medicare trust fund. It would not result in added efficiency or cost-effectiveness, but rather in increased costs and decreased competition. There simply is no sound economic or philosophical argument for the abolition of ODR.

Congresswoman Barbara Mikulski has introduced H.R. 2841, which would preserve ODR. A parallel bill, S. 1419, was introduced by Senator Paul Sarbanes. We strongly support these bills and any measures which would ensure the continuation of ODR.

This concludes my testimony. Thank you for giving me the opportunity to appear today. I would be pleased to respond to any questions you might have.

Chairman Jacobs. Mr. Healy.

STATEMENT OF KENNETH HEALY, DIRECTOR OF MEDICARE OPERATIONS, MEDICAL PERSONNEL POOL OF AMERICA, ON BEHALF OF THE HOME HEALTH SERVICES AND STAFFING ASSOCIATION

Mr. Healy. I am the director of medicare operations for Medical Personnel Pool, and I am here today representing the Home Health Services and Staffing Association.

On behalf of the association, I want to thank you for the opportunity to appear before you today to discuss the need to retain HCFA's Office of Direct Reimbursement as an optional intermediary for home health agencies.

It is not my purpose to reargue questions of statutory interpretation. HCFA's argument is that by eliminating ODR's workload, money and personnel slots will be saved. That is true only so far as HCFA's own administrative budget is concerned.

In fact, of course, the personnel costs will become a part of the intermediaries' budgets. That is not going to save money. Moreover, switching to other intermediaries will cost from $10,000 to $30,000 per home health agency, which will be reimbursed by medicare. That will hardly save money, either.

Finally, few intermediaries are ready to deal with claims processing through electronic data processing as is ODR. That means going back to far less efficient and more costly paper and manual processing.

So there is no savings there. All in all, eliminating ODR will cost money, not save it.

HCFA seeks to justify its policy on ideological grounds by saying that intermediary functions properly belong in the private sector. But that argument draws a veil of high-sounding words over a reality that is starkly different.

First of all, the "private sector" intermediary system is subject to a bookcase full of Federal statutes, regulations, manual orders, and informal policy instructions.

Second, the intermediary designations for home health agencies were made without competitive bidding or any other meaningful mechanism to assure that HCFA gets the best deal. Forty-four out of the total of 50 designated home health intermediaries are Blue Cross plans.

Third, once an intermediary has been granted its monopoly, there is no realistic way to break its hold. Yes, we know: HCFA has evaluation criteria for judging intermediary performance and will have the power to correct problems as they arise.

We hear the words, but we have serious doubts that HCFA will ever be able to make significant changes in intermediary monopolies, except in cases of flagrant and obvious abuse. This is especially true if there is no optional intermediary standing by as an alternative.

In short, HCFA may use the jargon of the private sector. What they are really talking about is granting perpetual monopolies. We submit that this has little to do with a healthy private sector. It has more to do with administrative convenience and preferences.

It will destroy an important source of data and experience. Just at the time that more beneficiaries are using home services, just as medicare officials are beginning to pay more attention to home care, just as lack of data is being recognized as an obstacle to sound policymaking, HCFA proposes to disband the largest single source of data and experience on home care intermediary functions. This is so shortsighted as to be virtually inexplicable.

Last, it contradicts clear congressional expectations. When Congress approved the 1980 Omnibus Reconciliation Act, the conference committee report included a direction to the HHS Secretary to designate regional intermediaries for home health agencies.

At the same time, the report specifically stated:

> In requiring the designation of regional intermediaries for home health agencies, it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration.

Whatever the legal implications of this conference report statement, we think Congress had sound reasons, as a matter of policy, for expressing its expectations that the direct dealing intermediary function should be maintained. Those reasons are just as good today as in 1980.

Finally, Mr. Chairman, let me point out that all of the foregoing reasons for retaining ODR apply equally to all home health agencies. For multilocation agencies, the argument of program and administrative efficiencies are even more compelling.

HCFA, in spite of protestations to the contrary, is not capable of assuring a multilocation provider consistency in coverage determinations and claims processing.

On August 2, 1983, HCFA published in the Federal Register a notice of proposed rulemaking which would, in effect, terminate ODR as an intermediary for home health agencies and other classes of providers.

We have submitted comments on the proposal, and I would like them to be included in the hearing record.

In general, we are pleased that the proposed regulation allows for a single intermediary for multilocation organizations. This is a constructive change in HCFA policy compared to that expressed at the time we were compelled to file our 1981 lawsuit.

We think it reflects attention to the merits of our arguments and an awareness of factors which, in actual practice, help achieve medicare intermediary efficiency and effectiveness.

Although the proposed regulation represents a very welcome step forward, several aspects of the single intermediary alternative need to be spelled out in the regulation.

For example—definition of a chain organization—range of functions to be performed by the single intermediary, provision for handling the fiscal impact of a change in intermediaries and for a transition plan agreed to by all parties, a requirement that HCFA exercise its discretion reasonably when rejecting a provider's choice of a single intermediary, requirements of reasonable notice when new designated intermediaries are announced or when a provider is switched from ODR, more definition to the role of the ombudsman mentioned in the preamble to the proposal, and strengthened intermediary selection and evaluation criteria.

All of our suggestions are aimed at improving the fiscal intermediary structure for home health agencies. Allowing a single intermediary for multilocation organizations and retaining ODR as an optional intermediary will help provide a sound, responsive, efficient intermediary structure.

We believe that as HCFA continues to give more attention to the merits of the home health agency position, and reflects that attention in its regulations and policy, we all can reach reasonable, workable accommodations.

The progress HCFA made over the past several months is evidence of that possibility. More needs to be done. We appreciate your interest in helping us to do it.

Thank you for the opportunity to appear this morning.

Chairman JACOBS. Mr. Healy, you had two "finally's" and one "last" in your statement, and you ran over 2 minutes.

[The prepared statement follows:]

STATEMENT OF HOME HEALTH SERVICES AND STAFFING ASSOCIATION, PRESENTED BY KENNETH A. HEALY, DIRECTOR OF MEDICARE OPERATIONS, MEDICAL PERSONNEL POOL OF AMERICA

Mr. Chairman and members of the committee: My name is Ken Healy. I am Director of Medicare Operations for Medical Personnel Pool and am here today representing the Home Health Services and Staffing Association.

On behalf of the Association, I want to thank you for the opportunity to appear before you today to discuss the need to retain HCFA's Office of Direct Reimbursement as an optional intermediary for home health agencies.

1. BACKGROUND

Our Association's members are investor-owned, taxpaying organizations, which provide both home health care services and supplemental nursing services through over 1,000 offices in 44 states. Our members are: Alpha Nurses, Inc., Kelly Health Care, Inc., Kimberly Services, Inc., Manpower, Inc., Medical Personnel Pool, Norrell Corporation, Nursefinders, Olsten Corporation, OMNA Health Care Services, Inc., Professional Nurses Bureau, Inc., Quality Care, S.R.T. Med-Staff International, Staff Builders, Inc., TAC/Medical Services, Inc., Temporaries, Inc., and Upjohn Health-Care Services, Inc.

By our most recent count, our members served more than 200,000 people and employed more than 160,000 persons in either a full-time or part-time capacity. We estimate that approximately 60 percent of our total employees are home health aides while approximately 15 to 20 percent are registered nurses and licensed practical nurses. The largest percentage of our home care patients are private pay; that is, the costs of their care are borne by private insurance coverage or out-of-pocket payments. However, an increasing number of our patients are funded by medicare (title XVIII of the Social Security Act), medicaid (title XIX), Social Services (title XX), and the Older Americans' Act (title III).

The home care services our members provide include professional nursing care; physical, occupational, or speech therapy; medical social services; home health aide services; medical supplies and equipment; and homemaker services.

Since the Medicare program began in 1965, all kinds of providers have been able to deal directly with the Secretary as their fiscal intermediary. This right to deal directly is founded on the Social Security Act and was reaffirmed by specific Congressional statement as recently as 1980. Today approximately some 479 home health agencies and 687 other providers deal directly with the Secretary, acting through an arm of the Health Care Financing Administration known as the Office of Direct Reimbursement. In 1980, Congress, supported by home health providers, directed the Secretary of Health and Human Services to designate regional intermediaries for home health agencies, but stated that the right to deal directly with the Secretary was not affected.

It is not my purpose to reargue questions of statutory interpretation involved in the lawsuit brought in December 1981 by HHSSA, National Association for Home Health Agencies, a predecessor to the National Association for Home Care, and some three dozen home health providers. Rather, I want to explain why terminating ODR as an optional fiscal intermediary makes poor program sense.

2. ELIMINATING ODR: POOR PUBLIC POLICY

A. It will cost more

HCFA's argument is that by eliminating ODR's workload, money and personnel slots will be saved. That's true only so far as HCFA's own administrative budget is concerned. In fact, of course, the personnel costs will become a part of the intermediaries' budgets. That's not going to save money. Moreover, switching to other intermediaries will cost from $10,000 to $30,000 per home health agency, which will be reimbursed by Medicare. That's hardly a savings either. Finally, few intermediaries are ready to deal with claims processing though electronic data processing as is ODR. That means going back to far less efficient and more costly paper and manual processing. So there's no savings there. All in all, eliminating ODR will cost money, not save it.

B. It will hurt beneficiaries

Anything that makes the Medicare system operate less efficiently really hurts only one group of people—Medicare beneficiaries. For providers, the extra hassle and unnecessary time and frustrating inefficiencies are, in the end, reimbursed by Medicare. It is, for example, the 75-year old widow living alone, with no close family, who will bear the brunt of this misguided policy. Delays in eligibility determinations and claims processing will hurt her and other Medicare beneficiaries in ways that cannot be corrected.

C. It grants an unchallengeable monopoly

HCFA seeks to justify its policy on ideological grounds by saying that intermediary functions properly belong in the private sector. But that argument draws a veil of high-sounding words over a reality that is strikingly different. First of all, the "private sector" intermediary system is subject to a bookcase full of Federal statutes, regulations, manual orders, and informal policy instructions. Second, the intermediary designations for home health agencies were made without competitive bidding or any other meaningful mechanism to assure that HCFA gets the best deal. Forty-four out of the total of 50 designated home health intermediaries are Blue Cross plans. Third, once an intermediary has been granted its monopoly, there is no realistic way to break its hold. Yes, we know: HCFA has evaluation criteria for judging intermediary performance and will have the power to correct problems as they arise. We hear the words, but we have serious doubts that HCFA will ever be able to make significant changes in intermediary monopolies, except in cases of flagrant and obvious abuse. This is especially true if there is no optional intermediary standing by as an alternative.

In short, HCFA may use the jargon of the private sector. What they're really talking about is granting perpetual monopolies. We submit that this has little to do with a healthy private sector; it has more to do with administrative convenience and preferences.

D. It will destroy an important source of data and experience

Just at the time that more beneficiaries are using home services, just as Medicare officials are beginning to pay more attention to home care, just as lack of data is being recognized as an obstacle to sound policy-making, HCFA proposes to disband the largest single source of data and experience on home care intermediary functions. This is so short-sighted as to be virtually inexplicable.

E. Lastly, it contradicts clear congressional expectations

When Congress approved the 1980 Omnibus Reconciliation Act, the conference committee report included a direction to the HHS Secretary to designate regional intermediaries for home health agencies. At the same time, the report specifically stated:

"In requiring the designation of regional intermediaries for home health agencies, *it is not the intent of the conferees that home health agencies would be precluded from contracting directly with the Health Care Financing Administration.* (Emphasis added).

Whatever the legal implications of this conference report statement, we think Congress had sound reasons, as a matter of policy, for expressing its expectations that the direct dealing intermediary function should be maintained. Those reasons are just as good today as in 1980.

Finally, Mr. Chairman, let me point out that all of the foregoing reasons for retaining ODR apply equally to all home health agencies. For multi-location agencies, the argument of program and administrative efficiencies are even more compelling. HCFA, in spite of protestations to the contrary, is not capable of assuring a multi-location provider consistency in coverage determinations and claims processing.

3. FURTHER COMMENTS ON HCFA'S PROPOSED REGULATION SUBSTANTIALLY REDUCING ODR'S ROLE AS A FISCAL INTERMEDIARY

On August 2, 1983, HCFA published in the *Federal Register* a Notice of Proposed Rulemaking which would, in effect,, terminate ODR as an intermediary for home health agencies and other classes of providers. We have submitted comments on the proposal, and I would like them to be included in the hearing record.

In general, we are pleased that the proposed regulation allows for a single intermediary for multi-location organizations. This is a constructive change in HCFA policy compared to that expressed at the time we were compelled to file our 1981 lawsuit. We think it reflects attention to the merits of our arguments and an awareness of factors which, in actual practice, help achieve Medicare intermediary efficiency and effectiveness.

Although the proposed regulation represents a very welcome step forward, several aspects of the single intermediary alternative need to be spelled out in the regulation, e.g.:

Definition of a chain organization; range of functions to be performed by the single intermediary; provision for handling the fiscal impact of a change in intermediaries and for a transition plan agreed to by all parties; a requirement that HCFA exercise its discretion reasonably when rejecting a providers choice of a single intermediary; requirements of reasonable notice when new designated intermediaries are announced or when a provider is switched from ODR; more definition to the role of the ombudsman mentioned in the preamble to the proposal; and strengthened intermediary selection and evaluation criteria.

4. CONCLUSION

All of our suggestions are aimed at improving the fiscal intermediary structure for home health agencies. Allowing a single intermediary for multi-location organizations and retaining ODR as an optional intermediary will help provide a sound, responsive, efficient intermediary structure. We believe that as HCFA continues to give more attention to the merits of the home health agency position, and reflects that attention in its regulations and policy, we all can reach reasonable, workable accommodations. The progress HCFA made over the past several months is evidence of that possibility. More needs to be done. We appreciate your interest in helping us do it.

Thank you for the opportunity to appear this morning.

Chairman JACOBS. The next witness is Congressman Russo's turf.

Mr. RUSSO. It is a pleasure to welcome Bill Turf, who is the administrator of a professional home health service which has his home office in my district. He has been serving my constituents since 1977.

We look forward to your testimony. Don't worry about going over.

STATEMENT OF WILLIAM S. TURF, DIRECTOR AND PRESIDENT, PROFESSIONAL HOME HEALTH CARE, INC., ON BEHALF OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

Mr. TURF. Mr. Chairman, my name is William Turf, I am administrator of a home health agency in Chicago. I am here today as the representative of the American Federation of Home Health Agencies, a national association representing the concerns of both nonprofit and proprietary home health agencies and the patients they serve throughout the country.

The American Federation of Home Health Agencies strongly opposes HCFA's proposal to phase out ODR for a number of reasons.

Elimination of ODR will: One, increase medicare administrative costs; two, limit HCFA's monitoring of other intermediaries; three, lead to poorer service for medicare beneficiaries by removing the element of competition for designated State home health intermediaries; four, remove a valuable resource for HCFA to use to evaluate intermediaries; five, reduce HCFA's ability to improve billing and audit systems of the intermediaries; and, six, disregard the recommendation of President Reagan's own Grace Commission.

These points are discussed more extensively in my full statement, which I am submitting for the record with your permission.

HCFA's move to phase out ODR is particularly ill advised at a time when medicare costs continue to increase. Significantly, HCFA officials have not contended that their action is a cost-saving move.

President Reagan's Grace commission, composed of executives of leading American corporations, states that elimination of ODR will result in increased costs to medicare. We emphatically agree.

The commission has urged the administration to reconsider the phaseout of ODR, even while making recommendations for over

$100 billion worth of savings and program cuts by eliminating Government-performed functions.

HCFA, however, states that its action is "in keeping with the President's goal to contract out to the private sector functions now performed by the Government."

We agree that there are many areas where functions can be more properly performed by the private sector. But programs must be considered in their context. There could be no more proper domestic role for the U.S. Government than that of assuring the fiscal integrity of our Nation's most massive health care program, a program which has a vital impact on the life of virtually every older American.

It is the duty of the Federal Government to work with every means available to insure the most effective and responsive administration of medicare, which is, after all, a program financed by the hard-earned dollars of the American taxpayers.

An in-house system is essential to developing and maintaining control in any large organization. When 72 out of 74 intermediaries are less cost effective than ODR, the situation requires more rather than less monitoring.

ODR, HCFA's in-house system, should be used as a yardstick against which to measure other intermediaries to determine why their costs per claim range all the way up to $4.86 compared to ODR's $2.73.

We believe elimination of ODR would constitute a wasted opportunity for HCFA to develop a model in-house intermediary against which to measure the performance of the other intermediaries. Evaluation of intermediaries will be all the more difficult once the yardstick—ODR—is gone.

Furthermore, we do not believe it is in the best interests of medicare beneficiaries to turn the intermediary function over to a near-monopoly of a single health insurance organization. With ODR out of the picture, Blue Cross will serve, without competition, as intermediary to home health agencies in 45 out of the 50 States.

What incentive would Blue Cross have to upgrade performance and bring down costs when HCFA has destroyed its most effective tool for monitoring the intermediary function?

Analysis of my own agency indicates that a return to Blue Cross of Illinois would result in a one-time conversion cost of almost $49,000, on top of ongoing costs resulting from higher costs per claim. There would be a $2,000 intermediary claims processing cost.

I would be pleased to review these figures for the committee staff.

We have an in-depth study we have done. Based on the analysis, we estimate that the 1,200 ODR providers will experience significant transition costs, and we believe the total cost of the phaseout will be in excess of $60 million.

I would be delighted to discuss this with the members of the committee.

A return to our previous intermediary means we would have to leave the highly sophisticated automated system employed by ODR and go back to a paper-processing operation. The energies of our professional and clerical staff to a large extent would again be devoted to trying to cope with the burden created by inefficient, unresponsive paper systems.

Ultimately, it is the patient who will be affected as staff must be concerned with moving paper instead of with treating patients.

I ask your permission to submit the rest of my statement for the record.

[The prepared statement and material referred to follow:]

STATEMENT OF THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES, PRESENTED BY WILLIAM S. TURF, ADMINISTRATOR AND PRESIDENT, PROFESSIONAL HOME HEALTH CARE, INC.

Mr. Chairman, my name is William Turf. I am here today as the representative of the American Federation of Home Health Agencies, a national association representing the concerns of both nonprofit and proprietary home health agencies and the patients they serve throughout the country. I am also Director and President of Professional Home Health Services of Evergreen Park and Skokie, Illinois. My agency is a nonprofit ODR provider. Until June, 1982, Blue Cross of Illinois served as my intermediary, so I have had experience with both Blue Cross and ODR.

The American Federation of Home Health Agencies strongly opposes HCFA's proposal to phase out ODR for a number of reasons. Elimination of ODR will:

1. increase Medicare administrative costs
2. limit HCFA's monitoring of other intermediaries
3. lead to poorer service for Medicare beneficiaries by removing the element of competition for designated State home health intermediaries
4. remove a valuable resource for HCFA to use to evaluate intermediaries
5. reduce HCFA's ability to improve billing and audit systems of the intermediaries, and
6. disregard the recommendation of President Reagan's own Grace Commission

These points are discussed more extensively in my full statement which I am submitting for the record, with your permission.

HCFA's move to phase out ODR is particularly ill-advised at a time when Medicare costs continue to increase. Significantly, HCFA officials have not contended that their action is a cost-saving move. President Reagan's Grace Commission, composed of executives of leading American corporations, states that elimination of ODR will result in increased costs to Medicare. We emphatically agree. The Commission has urged the Administration to reconsider the phase out of ODR, even while making recommendations for over a hundred billion dollars worth of savings and program cuts by eliminating government performed functions.

HCFA, however, states that its action is "in keeping with the President's goal to contract out to the private sector functions now performed by the government."

We agree that there are many areas where functions can be more properly performed by the private sector. But programs must be considered in their context. There could be no more proper domestic role for the United States Government than that of assuring the fiscal integrity of our nation's most massive health care program, a program which has a vital impact on the life of virtually every older American. It is the duty of the Federal Government to work with every means available to insure the most effective and responsive administration of Medicare, which is, after all, a program financed by the hard-earned dollars of the American taxpayers.

An in-house system is essential to developing and maintaining control in any large organization. When 72 out of 74 intermediaries are less cost-effective than ODR, the situation requires more rather than less monitoring. ODR, HCFA's in-house system, should be used as a yardstick against which to measure other intermediaries to determine why their costs per claim range all the way up to $4.86 compared to ODR's $2.73.

We believe elimination of ODR would constitute a wasted opportunity for HCFA to develop a model in-house intermediary against which to measure the performance of the other intermediaries. Evaluation of intermediaries will be all the more difficult once the yardstick--ODR--is gone.

Furthermore, we do not believe it is in the best interests of Medicare beneficiaries to turn the intermediary function over to a near monopoly of a single health insurance organization. With ODR out of the picture, Blue Cross will serve, without competition, as intermediary to home health agencies in 45 out of the 50 states. What incentive would Blue Cross have to upgrade performance and bring down costs when HCFA has destroyed its most effective tool for monitoring the intermediary function?

Analysis of my own agency indicates that a return to Blue Cross of Illinois would result in a one-time conversion cost of almost $49,000, on top of ongoing costs resulting from higher costs per claim. I would be pleased to review these figures with Committee staff.

ODR now serves approximately 1200 providers. Each provider will experience significant transition costs, and we believe the total costs of the phase out will be several million dollars.

A return to our previous intermediary means we would have to leave the highly sophisticated automated system employed by ODR and go back to a paper-processing operation. The energies of our professional and clerical staff to a large extent would again be devoted to trying to cope with the burden created by inefficient unresponsive paper systems. Ultimately, it is the patient who will be affected as staff must be concerned with moving paper instead of with treating patients.

I ask your permission to submit the rest of my statement for the record.

1. Contracting out of Direct Reimbursement Function Will Add to Overall Medicare Program Costs

AFHHA believes that contracting out of the direct reimbursement function will add to the overall costs of the Medicare program. Our preliminary estimates project a one-time cost of at least $67 million in transition costs to providers who are transferred, plus significant ongoing costs to providers due to increased claims processing administrative costs. In addition, there will be an additional ongoing cost to the government to process the approximately 2,100,000 claims ODR receives and processes each year.

These cost increases will be experienced because: (1) providers that are switched to other intermediaries will be required to change or scrap existing electronic billing systems designed to interface with ODR and will have to train and re-educate employees to implement the new systems of the designated State intermediaries to which they are transferred, (2) the new systems are not likely to be as automated as ODR's, thus higher ongoing claims processing costs will be incurred, and (3) since ODR has the second lowest unit processing cost per claim of all 74 intermediaries, redistribution of ODR's claims load among designated State home health intermediaries, all but one of which have higher unit processing costs than ODR, will produce ongoing Medicare cost increases.

ODR uses a cost efficient electronic billing system which eliminates the extensive paper work inherent in most intermediary processes. I and others who were previously served by State intermediaries and then switched to ODR experienced administrative savings ranging from $20,000 - $50,000 for the initial transfer year due to the elimination of paperwork. HCFA has indicated that if the State intermediary is unable to accomodate the automated provider by the date of transfer, alternative intermediaries would be offered who can accomodate automated billing. However, these intermediaries have not been identified, and the regulations say nothing about this concern.

We are unaware that there are any sizeable number of designated State intermediaries that have the capability of processing bills electronically. HCFA's data show that for the quarter October - December 1982, only sever intermediaries excluding ODR, processed home health bills in machine readable form. Of those, only three processed more than 1/3 of the home health bills received in machine readable form. And, all of these intermediaries had higher unit costs than ODR.

Given the lack of any indicated capability of most designated State intermediaries to meet ODR's electronic capability and the fact that their unit claims processing costs are higher than ODR's (with one exception) we can only conclude that HCFA's decision would result in significantly higher costs to providers and to the Medicare program.

2. HCFA's Ability to Monitor Costs of Other Intermediaries Becomes Limited with Phase out of ODR

ODR could serve as an extremely valuable resource to HCFA in assisting it to evaluate the claims processing costs of other intermediaries. HCFA has first-hand knowledge of how ODR goes about processing claims. It can set a standard of performance that it believes all intermediaries should be achieving and can measure ODR's costs and compare them with the costs of its other intermediaries. In this way it could effectively control intermediaries whose costs are out of line. If ODR can process claims at a unit cost of $2.73, as it did for FY 1982, HCFA could determine why 72 other intermediaries, with unit costs ranging up to $4.86, cannot achieve this level. Given the concern about the rising cost of government in general, and Medicare in particular, we do not believe HCFA should do away with a resource as valuable as ODR.

3. Removal of Competitive Element Could Lead to Operating Inefficiencies

Continuation of ODR would preserve the competitive element now existing between ODR and the designated State intermediaries.

The existence of ODR as an alternative for providers dealing with designated State intermediaries means that providers always retain the option of requesting a transfer to ODR if their designated intermediary's performance deteriorates. Designated intermediaries must be continuously aware that besides HCFA's evaluation of their performance another more direct performance measure exists---the ability of providers to bring substandard performance to HCFA's attention in the most direct way possible i.e., requesting a transfer to ODR. Performance encompasses not only the ability of intermediaries to carry out their designated responsibilities relative to providers, but also to be responsive to provider inquiries on behalf of beneficiaries.

With the impending demise of ODR, we are becoming aware of instances of deterioration of the performance of some intermediaries. For example, some intermediaries are no longer willing to explain Medicare coverage guidelines to providers so they will know which cases Medicare will reimburse and the number and type of visits that would be reimbursable. Some intermediaries have cut back on their telephone service making it difficult for providers to know whether particular cases would be covered. This has an adverse impact on families who are unable to get information about whether Medicare will pay their bills.

Without ODR, a further erosion of service could well occur as intermediaries find that in a monopolostic environment they no longer have to be concerned that providers have any other place to turn.

HCFA may well maintain that given poor performance by an intermediary, HCFA would switch to another. However it is extraordinarily complex and expensive for HCFA to go through the process of phasing out and selecting a new intermediary.

4. ODR Should Be Used To Evaluate Performance of Other Intermediaries To Obtain Greater Program Consistency

ODR, as a national intermediary, has providers in most of the States. Thus, HCFA is in the advantageous position of being able to compare ODR's experience with providers in the same geographic locations as those served by designated State intermediaries. Where significant deviations occur between ODR's experience and that of the State intermediary, these should be flagged by HCFA for prompt investigation. By doing this HCFA could assure greater consistency of program administration across the nation. HCFA could use ODR to measure inconsistencies in such areas of performance as coverage, processing times for reviewing claims, denial rates, timeliness of cost settlements, proportion of cases reversed on appeal, and number and kinds of complaints against performance.

HCFA should make ODR the model intermediary, against which to compare the performance of all other intermediaries and to achieve major efficiencies in program performance. HCFA's contention that doing away with ODR will contribute to program effectiveness is simply not true.

5. Loss of ODR Restricts Government's Ability To Experiment With New Bill Processing Systems

ODR should also be used as the Medicare experimental intermediary for developing techniques for more cost-efficient processing of claims. ODR has over the years been in the forefront in developing improved systems for processing claims. Private industry makes extensive use of in-house research components for development of new products and processes. ODR is that component for HCFA to use in the Medicare bill paying process.

More resources should also be earmarked for ODR to use in experimenting with improved systems for claims processing and for other aspects of intermediary responsibility. HCFA has a powerful resource at hand for improving Medicare administration and saving large amounts of money.

6. HCFA's Action Contrary to Recommendations of President Reagan's Own Private Initiative Task Force

HCFA's action is contrary to the recommendations of President Reagan's own private sector task force on cost control. This task force, comprising major executives of such prestigious companies as Bank of America and Goodyear, carefully reviewed the functions of the Department of Health and Human Resources, as well as other major Federal agencies. It recommended over $100 billion in savings and urged that a number of governmental functions be transferred to the private sector. There was a notable exception--ODR.

The Grace Commission maintains that HCFA based its ODR decision on faulty data. It argued, as AFHHA does, that elimination of ODR would increase Medicare costs and remove any element of competition for other intermediaries in servicing claims. The Grace Commission also expressed its concern about the loss of ODR as an "in-house laboratory" for developing intermediary efficiencies.

In conclusion, at a time of generally acknowledged concern about high government expenditures and a looming financial crisis in the Medicare trust fund, we feel it is incumbent on the government to produce convincing evidence that its proposed action will not produce significant cost increases for providers and thus for the Medicare program. The mere statement that HCFA determined that the impact will be insignificant does not in our judgment suffice, in view of the indications that the elimination of ODR will likely result in the unnecessary expenditure of significant Federal funds and have an adverse impact on the administration of the Medicare program.

I appreciate the opportunity of testifying today, and would be happy to answer any questions that members of this Committee may have.

AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.
429 N Street S.W. • Suite S-605 • Washington, D.C. 20024 • (202) 554-0526

September 27, 1983

Mr. John J. Salmon
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Salmon:

As you requested September 20, I am returning the transcript of Mr. William Turf's testimony furnished before the Subcommittee on Health on September 14, 1983. I have made some minor corrections on the transcript. I am also enclosing a correction of page 4 of Mr. Turf's prepared testimony that contained a typographical error.

You will note that on page 60 of the transcript Mr. Turf refers to an in-depth study of the transition costs involved in a transfer of ODR providers. I am enclosing a copy of Mr. Turf's study and request that it be inserted in the record.

This study shows that total first year excess costs to be $69,315,413 and total 10 year excess costs to be $619,769,630. (HCFA stated at the hearing that it would take a decade to convert contract intermediaries to electronic billing. I understand that more recently they advised Chairman Jacobs it would take several years.) These figures are made up of three elements: (1) the estimated costs of converting the ODR providers to contracting intermediaries-$29,353,800; (2) the ongoing costs to the Medicare Trust Fund that will be incurred until all intermediaries have attained ODR's present electronic billing capability-$22,015,350; and (3) the excess charge to the Medicare Trust Fund that comes about because all but two intermediaries (ODR and Philadelphia Blue Cross) have unit claims processing costs that are higher than ODR, i.e., $39,961,613. The latter figure represents what it costs the Medicare Trust Fund because practually all intermediaries are not as cost-effective as ODR.

In arriving at these estimates Mr. Turf assumed that only one-half of the 1200 ODR providers were on electronic billing. I would also point out that Mr. Turf's cost estimates were based on what it would cost a home health agency to transfer from ODR to another intermediary. Home health agencies have a less complicated structure and cost reporting process than hospitals. Accordingly, the transition costs for hospitals should be significantly higher than used in Mr. Turf's analysis thus there should be a further increase in costs to the government.

PRESIDENT, John Beard • **VICE PRESIDENT,** Joan Buddi • **SECRETARY,** Kyle Altman
TREASURER, Alan Spector • **EXECUTIVE DIRECTOR,** Morrie Levy

Actually, these costs are understated for another reason, since Mr. Turf did not include the additional costs that would be incurred if ODR's current 2,100,000 workload is distributed among the other intermediaries as would be the case if ODR is phased out. Using Mr. Turf's assumptions and applying the average $1.065 cost per claim figure used in Mr. Turf's analysis, produces an additional cost of $2,236,500 or a total excess intermediary claims processing cost for the first year of $42,198,113. This results in total first year excess costs of $71,551,913 and corresponding increases when projections are made, as Mr. Turf has, for 10 years.

Arguably, it could be maintained that 10 year projected costs may be less than Mr. Turf projected because other intermediaries will adopt ODR's electronic system. On the other hand, without ODR as the benchmark for measuring costs of other intermediaries, there could be a significant increase in intermediary costs beyond that accounted for by the inflation rate.

Sincerely yours,

Morrie Levy

Morrie Levy
Executive Director

ML/ms
cc: William Turf, Administrator, Professional H.C. Inc.
John Beard, President. AFHHA
Joan Buddi, Vice President, AFHHA

PROFESSIONAL HOME HEALTH CARE, INC.
CARE AND COMFORT AT HOME FOR THE ILL
SINCE 1977

VISITING NURSES
PHYSICAL THERAPY
OCCUPATIONAL THERAPY
SPEECH THERAPY
MEDICAL SOCIAL WORK
HOME HEALTH AIDES
NUTRITIONAL GUIDANCE

MAIN OFFICE:
2400 West 95th St.
Evergreen Pk., IL 60642
CHICAGO 581-2150
SUBURBAN 423-4000

BRANCH OFFICE:
9933 Lawler Ave.
Skokie, IL 60077
CHICAGO 784-1200
SUBURBAN 674-1230

September 23, 1983

Mr. Morrie Levy
AFHHA
429 N Street, SW-Suite 605
Washington, D.C. 20024

RE: Retention of ODR
Submission of testimony to the House Ways & Means Health Sub-Committee

Dear Mr. Levy:

I have enclosed all the data pertinent to my testimony before the House Ways & Means Health Subcommittee. This letter reflects the facts that are available to us. The assumptions are very conservative and probably reflect the minimum loss to the Medicare Trust Fund.

A sizable portion of the excess cost to Medicare is happening now. The only reason we can identify this massive excessive Intermediary claims processing cost is because ODR is operating and a comparison can be made. Obviously, the claims processing cost will skyrocket once ODR is abolished.

Enclosed also are the schedules of Professional Home Health Care, Inc Conversion Cost Analysis and the analysis of the Excess Intermediary Claims Processing Cost.

Fact:	PHHC 1st year conversion cost Schedule F (Electronic System to paper).	$48,923.00
Fact:	There are 1200 plus providers serviced by ODR.	
Assumption:	50% of the ODR providers are on the electronic system and 50% are on the paper system. 1200÷2=600	x600
	Estimated 1st year conversion cost	$29,353,800

Fact:	HCFA Adjusted Unit Cost Per Claim-October-September 1982. The total variance between ODR ranking 2nd from the lowest of 74 intermediaries is:		
	ODR	$ 2.73	
	74th ranking intermediary (HCFA schedule attached)	$ 4.86	
	Variance: Excess contractor cost	$ 2.13(A)	
Fact:	ODR services 5.3% of the total Medicare claims per HCFA statistics. That is, approximately 2,100,000 claims per year. Therefore, the total amount of Medicare claims processed by the remaining 94.7% of the contract intermediaries=	37,522,641	
Assumption:	50% of the claims are serviced by contract intermediaries that rank below the median and 50% are serviced by those intermediaries that rank above the median	$2.13(A)÷2=$1,065 X 37,522,641	
	Total excess intermediary claims processing cost currently	$39,961,613	
	Estimated 1st year provider's conversion cost	$29,353,800	
	Total 1st year excess cost		$69,315,413

Ten year excess cost based on the following:

HCFA stated at the Oversight Hearings that it would take a decade (10 years) to convert contract intermediaries to electronic billing.		
The continuing yearly cost to the Medicare Trust Fund for the transfer of ODR providers is equal to 75% of the 1st year conversion cost (See PHHC Cost Analysis-Schedule F).	$29,353,800 X75% $22,015,350	
Add the intermediary excess claim processing cost	$39,961,613 $61,976,963 X10 years	
Total 10 year excess cost		$619,769,630

Sincerely,

William S Turf

William S. Turf
ADMINISTRATOR

SCHEDULE A
CALCULATION OF INCREASE OF COST (Each Year B/C) TO PROCESS CLAIMS
TYPING DEPARTMENT
VARIENCES MEASURED IN MINUTES 6/1/82 - 5/31/83

	Form 1487	Billing Folders	Info Billing Folders	Form 2043	Form 2043A	Form MIF	Admit-Start of Care Form	Billing Card	Col-10 Line Total Minutes Admits	Doctors Orders	Form SMIF	Mail 1487 B/C Labor	Col.-14 LINE Postage	
	ADMIT	ADMIT	ADMIT	ADMIT	ADMIT	ADMIT	ADMIT	ADMIT	ADMITS	ADMIT + ½ ADMIT	CLAIM ADMITS	WORKING DAYS	WORKING DAY	
BC/BS	10	3	3	-0-	-0-	30	15	2	63	30	30	10	$ 140	
ODR	1	-0-	-0-	6	10	-0-	2	1	20	-0-	-0-	-0-	-0-	
Variance	9	3	3	(6)	(10)	30	13	1	43	30	30	10	140	
Multiplier (Schedule G-Lines 15-10-8-21)									946	1419	x1663	260	260	
Total Minutes									40678/60	42570/60	49890/60	2600/60		
Hours									678	709	831	43	$364	13
									709					
									831					
									43					
Total Hours (Excess B/C)									2261					
Average Clerical Hourly Rate (Schedule G Line 40)									x $ 7.52					
Total Excess									$17,003.00					
Medicare % of Total (Schedule G Line 49)									x.953429912					
Total Excess Blue Cross Costs to the Medicare Program Each Year									$16,211.00	21				

9/15/83-SUBMITTED BY:
PROFESSIONAL HOME HEALTH

SCHEDULE B
INCREASE COST (Each Year B/C) TO PROCESS CLAIMS
DIRECT LABOR CLERICAL EXPENSE OF PROCESSING CLAIMS-FILING ETC.
VARIENCES MEASURED IN MINUTES 6/1/83 - 5/31/83

	Billing Folder ADMIT	Source Doctor Folder ADMIT	Billing Card ADMIT	2043A + Admit-Start of Care ADMIT	ROE ADMIT	Col-7 Total Minutes ADMITS	Line RN,PT,OT ST Notes THERAPY VISITS	Summary of Services THERAPY VISITS	Total Minutes THERAPY VISITS	Doctors Orders ADMIT + ½ ADMIT	SMIF CLAIM -ADMIT	D/C & Readmit Slips	Copy of 1487 CLAIMS
B/C/BS	1	1	1	0	1	4	1	1	2	1	1	3	1
ODR	0	0	1	1	0	2	0	1	1	0	0	0	0
Variance	1	1	0	(1)	1	2	1	0	1	1	1	3	1
Multiplier (Schedule G-Lines 15-25-10-9-19-4)						946			4,886	1,419	1,663	1,455	2,609
Total Minutes						1,892/60			4,886/60	1,419/60	1,663/60	4,365/60	2,609/60
Hours						32 81 24 28 73 43			81	24	28	73	43
Total Hours (Excess B/C)						281							
Average Clerical Hourly Rate (Schedule G Line 40)						$ 7.52							
Total Excess						$2,113.00							
Medicare % of Total (Schedule G-Line 49)						x.953429912							
Total Excess B/C Costs to the Medicare Program						$2,015.00	28						

9/15/83-SUBMITTED BY:
PROFESSIONAL HOME HEALTH
PROVIDER #14-7150

PUBLISHED BY HCFA/BUREAU OF PROGRAM OPERATIONS

TABLE 1: ADJUSTED UNIT COST PER CLAIM -- OCTOBER-SEPTEMBER FY 1982

			ADJUSTMENTS FOR NONCONTROLLABLE VARIABLES		
RANK	INTERMEDIARY	UNIT COST PER CLAIM	SALARY INDEX	WEIGHTED RATIO OF INPATIENT, SNF, HHA, AND OTHER CLAIMS TO TOTAL CLAIMS PROCESSED	ADJUSTED UNIT COST PER CLAIM
1	PA.-PHILADELPHIA	$2.79	-$0.10	-$0.41	$2.28
**** 2	HCFA-ODR	$2.75	-$0.10	$0.08	$2.73
3	VIRGINIA-ROANOKE	$2.80	$0.15	-$0.17	$2.78
4	MARYLAND	$2.54	-$0.10	$0.41	$2.85
5	TEXAS	$3.37	-$0.13	-$0.36	$2.88
6	PA.-PITTSBURGH	$2.90	-$0.09	$0.11	$2.92
7	PRUDENTIAL	$3.46	-$0.13	-$0.37	$2.96
8	AETNA-FLORIDA	$4.65	$0.09	-$1.75	$2.99
9	CALIF.-LOS ANGELES	$3.40	-$0.37	-$0.01	$3.02
10	OREGON	$3.16	-$0.13	$0.00	$3.03
11	GEORGIA-COLUMBUS	$2.78	$0.17	$0.10	$3.05
12	KANSAS	$2.85	$0.06	$0.16	$3.07
13	RHODE ISLAND	$2.81	$0.11	$0.18	$3.10
14	IOWA-DES MOINES	$2.87	$0.12	$0.14	$3.13
	OKLAHOMA	$3.59	$0.00	-$0.46	$3.13
16	OHIO-CLEVELAND	$2.90	-$0.10	$0.38	$3.18
17	MICHIGAN	$3.00	-$0.29	$0.52	$3.23
18	ARKANSAS	$3.30	$0.12	-$0.17	$3.25
19	DISTRICT OF COLUMBIA	$3.65	-$0.20	-$0.19	$3.26
20	SOUTH CAROLINA	$3.01	$0.17	$0.10	$3.28
21	GEORGIA-ATLANTA	$3.14	-$0.15	$0.30	$3.29
22	WASHINGTON	$3.59	-$0.29	$0.06	$3.36
23	VIRGINIA-RICHMOND	$2.86	$0.08	$0.43	$3.37
24	MASSACHUSETTS	$3.25	-$0.19	$0.32	$3.38
	NORTH CAROLINA	$3.16	$0.15	$0.07	$3.38
26	PA.-WILKES-BARRE	$2.81	$0.16	$0.43	$3.40
27	IOWA-SIOUX CITY	$3.37	$0.16	-$0.11	$3.42
	MONTANA	$3.19	$0.14	$0.09	$3.42
	NEBRASKA	$3.42	$0.13	-$0.13	$3.42
	OHIO-CINCINNATI	$3.43	$0.03	-$0.04	$3.42
	W. VA.-CHARLESTON	$3.08	$0.19	$0.15	$3.42
32	AETNA-CALIFORNIA	$3.96	-$0.44	-$0.07	$3.45
33	ALABAMA	$3.52	$0.17	-$0.21	$3.48
34	FLORIDA	$3.40	$0.16	-$0.07	$3.49
	MINNESOTA	$3.28	$0.01	$0.20	$3.49
	W. VA.-WHEELING	$3.18	$0.19	$0.12	$3.49
37	AETNA-WASHINGTON	$4.00	-$0.29	-$0.21	$3.50
	ILLINOIS	$3.58	-$0.28	$0.20	$3.50
	MISSISSIPPI	$3.59	$0.17	-$0.26	$3.50
40	COLORADO	$3.51	-$0.15	$0.16	$3.52

TABLE 1: ADJUSTED UNIT COST PER CLAIM -- OCTOBER-SEPTEMBER FY 1982

			ADJUSTMENTS FOR NONCONTROLLABLE VARIABLES		
RANK	INTERMEDIARY	UNIT COST PER CLAIM	SALARY INDEX	WEIGHTED RATIO OF INPATIENT, SNF, HHA, AND OTHER CLAIMS TO TOTAL CLAIMS PROCESSED	ADJUSTED UNIT COST PER CLAIM
41	KENTUCKY	$3.64	$0.05	-$0.16	$3.53
42	LOUISIANA	$3.36	$0.15	$0.05	$3.56
43	PA.-HARRISBURG	$3.15	-$0.03	$0.47	$3.59
44	CONNECTICUT	$3.65	-$0.01	-$0.01	$3.63
	OHIO-COLUMBUS	$3.46	$0.02	$0.15	$3.63
	TRAVELERS-NEW YORK	$4.81	-$0.33	-$0.85	$3.63
47	UTAH	$3.45	$0.08	$0.13	$3.66
48	IDAHO	$3.34	$0.14	$0.19	$3.67
49	PA.-ALLENTOWN	$3.31	$0.05	$0.40	$3.76
	TENN.-CHATTANOOGA	$3.76	$0.20	-$0.20	$3.76
51	AETNA-CONNECTICUT	$3.31	-$0.04	$0.50	$3.77
52	OHIO-TOLEDO	$3.49	-$0.09	$0.38	$3.78
53	WISCONSIN	$3.66	-$0.09	$0.23	$3.80
54	INDIANA	$3.49	$0.07	$0.27	$3.83
55	HAWAII MEDICAL	$4.07	-$0.33	$0.11	$3.85
	NEW JERSEY	$3.76	-$0.24	$0.33	$3.85
57	NATIONWIDE	$4.31	$0.02	-$0.47	$3.86
58	WYOMING	$3.60	$0.19	$0.09	$3.88
59	AETNA-ILLINOIS	$4.53	-$0.01	-$0.63	$3.89
60	DELAWARE	$3.72	$0.10	$0.12	$3.94
61	CALIF.-OAKLAND	$3.88	-$0.29	$0.38	$3.97
	KAISER	$5.85	-$0.29	-$1.59	$3.97
	NORTH DAKOTA	$4.25	$0.17	-$0.45	$3.97
64	ARIZONA	$3.82	-$0.05	$0.23	$4.00
	NEW MEXICO	$3.72	$0.14	$0.14	$4.00
66	AETNA-PENNSYLVANIA	$3.61	-$0.10	$0.51	$4.02
	MUTUAL OF OMAHA	$4.47	$0.13	-$0.58	$4.02
68	TRAVELERS-MICHIGAN	$4.62	-$0.29	-$0.30	$4.03
69	NEW HAMPSHIRE	$3.65	$0.19	$0.24	$4.08
70	W. VA.-PARKERSBURG	$3.90	$0.19	$0.02	$4.11
71	MAINE	$3.37	$0.17	$0.67	$4.21
72	AETNA-NEVADA	$4.67	-$0.10	$0.05	$4.62
73	COOPERATIVA DE SEGUROS	$4.39	$0.53	-$0.24	$4.68
74	P. R.-JACKSONVILLE	$5.88	$0.29	-$1.31	$4.86

SCHEDULE C

CALCULATION OF INCREASE OF COST (EACH YEAR B/C) TO PROCESS CLAIMS

MANAGED BILLING DEPARTMENT
VARIANCE MEASURED IN MINUTES 6/1/83 - 5/31/83

BILLING	Printing, Tearing & Sorting 1487 From Computer CLAIM	Pull Billing Folders with Source Documents CLAIM	Match 1487 with Source Document CLAIM	Staple 1487 + Documents Together CLAIM	Copy Source Documents CLAIM	Check Frequency Screens CLAIM	Transmit 1487 CLAIM	Record Date 1487 Sent CLAIM	Record Date Payment Rec'd CLAIM	List Name of Patient Billed CLAIM
B/C	30	15	60	30	600	630	-0-	100	360	30
[illegible]	-0-	-0-	-0-	-0-	-0-	-0-	2	-0-	-0-	-0-
Variance	30	15	60	30	600	630	(2)	100	360	30
Multiplier (Schedule G)										
Total Minutes										
Hours										
Total Hours (Excess B/C)										
Billing Manager Hourly Rate (Schedule G-Line 53)										
Total Excess										
Medicare % of Total (Schedule G)										
Total Excess B/C Costs to the Medicare Program Each Year										

SCHEDULE C

Col-13

SCHEDULE C

BILLING	Total Minutes CLAIMS PER MONTH	Line	Record Date [illegible] Received ADMIT	Record Date [illegible] Sent ADMIT	Enter Admit-Start of Care Computer ADMIT	Enter 2043A in Computer (BOE) ADMIT	Transmit 2043A (BOE) ADMIT	Total Minutes ADMIT	Labor for Delivery of Bills MONTH	Delivery of Billing to B/C Labor MONTH	Total Minutes Delivery MONTH	Col. 13 Billing Delivery Costs MONTH	LINE
B/C	1,605		30	60	2	-0-	-0-	72	35	264	299	(Parking) 5.00	
[illegible]	2		-0-	-0-	2	1	2	5	-0-	-0-	-0-	-0-	
Variance	1,603		30	0	-0-	(1)	(2)	67	35	264	299	5.00	
Multiplier (Schedule G)	12							946			12	12	
Total Minutes	20,316/60							63,382/60			3,588/60		
Hours	339							1,056			60		
	1,056												
Total Hours (Excess B/C)	1,395										60		
Billing Manager Hourly Rate (Schedule G-Line 53)	x 10.88									(Schedule G Line 40)	x 7.52		
Total Excess	15,178.00										$ 451.00	$ 60.00	23
Medicare % of Total (Schedule G)	x.953429912										x.953429912		
Total Excess B/C Costs to the Medicare Program Each Year	$14,471.00									(A)	$ 430.00	$60.00	
	(A) 430.00												
	$14,901.00	23											

9/15/83-SUBMITTED BY:
PROFESSIONAL HOME HEALTH
PROVIDER# 14-7150

SCHEDULE D
DIRECT MATERIAL COST
6-1-82/5-31-83

			Col-7	Line
			TOTAL DIRECT MATERIAL COST	
Schedule A - Column 14-Line 13		$364.00		
Schedule C - Column 23-Line 23		60.00 $424.00	$424.00	
Printing Cost - For Manual B/C System			$1,140.00	
Excess Copier Cost (Schedule G-Line 4)	Average 9 Per Claim X 2,509 23,481 X .10 $2,348.00		$2,348.00	
TOTAL DIRECT MATERIAL COST			$3,912.00	20

9/15/83-SUBMITTED BY:
PROFESSIONAL HOME HEALT
PROVIDER #14-7150

CONVERSION COST - FROM ODR TO B/C

SCHEDULE E 6-1-82/5-31-83

ONE TIME LABOR CONVERSION COST

DEPARTMENT	TOTAL WORKING DAYS	DEPARTMENT COST	TOTAL COST	COL 7 LINE
Medical Administration Professional Staff	23	$ 2,192.48		
Nursing Staff	30	2,237.76		
TOTAL			$ 4,430.24	
Administrative Staff Managers and Assistants	60	6,563.60		
Clerical Staff	17	889.68		
TOTAL			7,453.28	
ALL DEPARTMENT TOTALS			$11,883.52	52

9/15/83-SUBMITTED BY:
PROFESSIONAL HOME HEALTH
PROVIDER #14-7150

SCHEDULE F
TOTALS OF ALL SCHEDULES - OF THE COMPARATIVE ANALYSIS OF ODR PROCESSING COSTS VERSUS B/C OF CHICAGO

Based on the actual data from the Cost Report of 6-1-82/5-31-83

Calculation of ODR/Blue Cross 12 Month Cost Variance

SCHEDULE	COLUMN	LINE	DIRECT/COST LABOR/MATERIAL		B/C EXCESS COST EVERY YEAR COST	TOTAL COST
A	10	21	$16,211.00			
B	7	28	2,015.00			
C	12	25	14,901.00			
D	7	20	______	$3,912.00		
			33,127.00	3,912.00 33,127.00		
B/C Excess Cost Each Year					$37,039.00	$37,039.00
		%	67%	8%		
		ONE TIME CONVERSION COST FROM ODR TO B/C				
E	7	52				$11,884.00
TOTAL COST						$48,923.00

9/15/83-SUBMITTED BY:
PROFESSIONAL HOME HEAI
PROVIDER #14-7150

SCHEDULE G
INDEX TO METHODOLOGY
BASED ON FISCAL
6-1-82/5-31-83

LINE	The units listed will identify the multiplier used in developing the total time for processing patient claims.		
	Patient Admissions (Unduplicated)	Admits	946
4	Patient Claims	Claims	2,609
	Monthly Information Forms	MIF	946
8	Semi-Monthly Information Forms (Claims Admits)	SMIF	1,663
10	Doctors Orders (Admit + Patients longer than 60 Days) (From Statistics) Admits 946 + ½ Admits 473 1,419		1,419
15	Unduplicated Census		946
	Duplicated Census (Internal Statistics)		1,392
19	- Discharge + Re-admits		1,455
21	Working Days		260
	Visits -	Total	26,294
25	Visits - Therapy Notes	All Therapies	4,886
27	Billing (Claims Each Month in Total)		12

Computation - Average Hourly Clerical Rate From Cost Report Statistics - 5-31-83

	Salaries	$ 119,175	
	Employee Benefits	31,443	
	Clerical Transportation Costs	2,593 153,211	
	Clerical Contract	6,222 159,433/10.1877	(21,190 Hrs. F.T.E.)
		15,649/2080	
40	Average Clerical Hourly Rate	7.52	

Calculation of Medicare % (From Cost Report 5-31-83)

	Total Medicare Costs (Worksheet C)	1,127,981
	Total Cost (Worksheet B)	1,183,077
49	Medicare %	.953429912
52	Billing Manager Hourly Rate	$ 10.88

9/15/83-SUBMITTED BY:
PROFESSIONAL HOME HEAI
PROVIDER #14-7150

Chairman Jacobs. Mr. Moore?

Mr. Moore. Mr. Howarth, one point you made in support of the point that transfer of the functions would cost money. The U.S. Court of Appeals, District of Columbia Circuit, decision found that the costs estimates is $10 to $30 million.

Mr. Howarth. Correct.

Mr. Moore. That calculation was based on the claims being done by intermediaries, being done by hand and not by electronic device?

Mr. Howarth. I could find out that for you. I don't know that specifically.

Mr. Moore. Staff informs me that was the case.

If the situation was one of forcing you back in time to handling these things by hand, certainly that is something none of us want any part of, but if in fact nobody is forced from ODR except to an intermediary that does handle it electronically, then we might not have that same cost.

As a comment, you heard the testimony of Mr. Bourque. I don't think any member of this subcommittee is going to go along with a proposition that forces you to go back to somebody handling it by paper, so the charge being leveled is inaccurate, because we are not going to go along with that.

We ought to talk about something else.

Mr. Howarth. Mr. Moore, the discussion has been around the claims processing area, the ability to submit a claim associated with, like submitting a bill. In reality, we are looking at a variety of functions that are computerized, the ability to do an eligibility inquiry, an eligibility response, a coverage inquiry.

You talk about the number of audits, ODR does that as an automatic interface at the front end of their system. We also look at the response on that coverage being done mechanically as well as the payment of the bill which is already being done mechanically, so we are not talking about claims processing capability within itself.

We are talking about the entire mechanical function and other intermediaries do not have that capability. We have been seeking it.

Mr. Moore. We are all seeking that in an effort to hold down costs. I ask that the record be left open at this point so we can get a clarification from the administration on the points Mr. Howarth just made, making sure that his commitment on not going to a nonintermediary forces you to go to nonelectronic.

Mr. Russo. You heard the administration talking about the $5,000 figure to make this transition. I believe I heard you say it will cost $60 to $80 million.

Mr. Turf, I would certainly hope that you would share the findings and studies that your agency has done with the committee so we can compare them against the cost analysis that we receive from HCFA.

You are talking about $60 million, and $49,000, significant amounts of dollars, not just small peanuts. I ask the chairman to leave the record open so that you can do that.

Would you comment on that $5,000 figure?

Mr. Howarth. Ludicrous would be the word.

Mr. Russo. Mr. Turf, you recently shifted from having Blue Cross as your intermediary to the Office of Direct Reimbursement. Could you tell us why you made that change?

Mr. Turf. We shifted on our last fiscal year, which started June 1, 1982. We have completed our first fiscal year with ODR, ending May 31, 1983.

The reasons we did it, first, our estimates on analysis, we estimated we would save somewhere around $38,000 by shifting to an electronic system. Blue Cross of Illinois had no interest in it.

As a matter of fact, we couldn't even discuss it with them. Since then, what we have found, in capsulated form, we have found this one-time cost saving of the—well, it is actually $49,923, which is also verified by our dropping of our total per visit cost by $3 a visit.

We have also found that we had a pleasant experience. We started dealing with an intermediary who was responsive on a business sense; that is to say, the testimony you have heard from other witnesses wherein that ODR is a professional organization dedicated to processing intermediary claims is true.

I have experienced 5 years with Blue Cross and 1 year with ODR. My background is, aside from being trained in public health, I was a consultant and I am an accountant. I can tell you, as a business manager, that we have been dealing with professional people at ODR who respond on a professional level to our professional people, whereas prior to that, we had experienced extreme difficulties in dealing with the Chicago Blue Cross, for a variety of reasons, some of which I wouldn't know. Their lower level people were not trained at all.

In many cases, they acted capriciously, and our proof of that is we have gone through the administrative process that Mr. Bourque mentioned. We had denied an extraordinarily large amount of claims from Blue Cross about 3 years ago after being on zero waiver practically for 3 years, and we couldn't understand it. They couldn't explain it.

The process of recovering those claims, not only being paid for, because we were paid on many of them, on waiver but of clearing the patient's record of being charged with them. It took 3 years through the administrative process, and we vindicated ourselves in our judgment by winning them back.

This past year with ODR, we have had a very strict agency, we have been on 100-percent medical review for the past 9 months, and maintained our review status 100 percent, and our professional people's understanding of the regulations is the same as their professional people, and where anything is in doubt, a discussion and proof are submitted, and a settlement is made.

So, aside from the fact that they have the electronic data processing capabilities, they also seem to only have one goal; that is, the processing of claims for the provider and the beneficiary in a businesslike manner, and I would venture to say that these private contracting intermediaries do not have that as their goal.

Home health is less than 5 percent of their business. They are in many other businesses, and why should they?

Mr. Howarth. I would like to adjust a little bit to that, and I will try to be brief, if I could. We also have been with another intermediary. We found, upon our decision to leave, that we claimed that they owed us some $250,000 in accounts receivable.

They claimed that they owed us $50,000 in accounts receivable. Over the next 4 years, we received all but $10,000 of the $250,000 that we claimed that they owed us.

We have also seen, in the last few months, with the transition of many of our agencies and the State to the designated State intermediary, that though there is good intent to support and sustain those agencies, there seems to be the inability to communicate with them in such a way as to improve the relationships with those home health agencies.

Mr. Russo. In the testimony we heard from HCFA this morning, they suggest that their guidelines and procedures for review would make it easy for you to complain if you have a problem.

Mr. Turf. Mr. Russo, there is an interesting sideline to that. They are talking about the ombudsman now. In 1974, the same problem existed. The providers were complaining terribly about the intermediary treatment of their patients and themselves.

At that time, HCFA instituted an onsite representative, so, in other words, there is an HCFA person on site in most intermediaries. One would never know it. They are supposed to be monitoring the intermediary.

We have never seen or heard from this person, so they have done this card trick before.

Mr. Russo. Well, let me ask you this. Assuming that the Office of Direct Reimbursement is eliminated, if Ms. Mikulski's bill is not passed and for some reason we are not able to do the things that you would like us to do, what policies would you like to see HCFA develop to help insure that you would not be subject to arbitrary practices by the private fiscal intermediary?

Mr. Turf. Mr. Russo, I don't think there is an answer to that and the reason is that we are discussing a monopoly. They simply are going to be and they are now for all practical purposes all powerful. As a small business provider, we only did about $1.5 million. We delivered 26,294 home visits and again we have had a 1-percent waiver status which is their means of measuring whether we can indeed evaluate the proper treatment for the patient, 2½ percent is excessive, over 2½ percent. We have never had any problem with our audits. I am a controller also, although we use an outside accounting firm for our proprietary agency. So, we have never had a lot of the problems some providers have. But again, there is no dealing with them.

What do you do if you call up and nobody answers? Whom do you do if you leave messages and nobody returns it? Whom do you go to?

Mr. ~~Russo.~~ The HCFA representative that is standing onsite.

Mr. Turf. Yes, right; he had probably been painted so blue we couldn't find him.

As a matter of fact, what we have found from a business viewpoint—and again this drains all the way down the pipeline to the patient care—what I have found as a businessman, as an accountant, as a person trained in public health, and I have had experience with the Center for Disease Control and so forth, is that we can work with the regulations as published. We have access to their personnel. Their personnel are professional and well trained. They respond. We can conduct our business. We can care for the patients and we can save money doing it. Now why in the world would we want to stop doing that?

There is another factor that is kind of interesting here. This cost analysis is rather extensive and this goes through direct labor, direct material costs, and indirect costs. You know this estimate in excess of $60 million cost is really very conservative because out of the 1,200 providers, there are 480 home health agencies.

As an organizational structure, we are the least complicated of all the providers except for physical therapy. The hospitals are much more complicated. The cost-reporting system that these figures are based on and we have completed our first year as I said with ODR is a standardized cost-reporting system and it is also a derivative of the hospital-cost-reporting system in that it is a step-down type of system and as such, if our first-year costs are going to be $49,000, it stands to reason that the remainder of the providers, those that aren't home health agencies, are going to experience costs far in excess of that because they are much more complicated organizational structures. They are capital incentive in terms of real estate and equipment whereas home health agencies are not.

So when I use the term "$60 million" based on this data which is the only data that we have access to, it is conservative.

Now, the final of that is this: 75 percent of this, or to be exact, $37,039, represents ongoing costs each year of performing processing with a different intermediary.

If we take a look at that and take 75 percent of the $60 million which is conservative, which is $45 million as a first-year transfer, and multiply that by 10 years, you have got a half million dollars that we are going to be shoveling down the coal chute by eliminating ODR. That is a lot of bucks.

Mr. **Russo**. I don't have any other questions, Mr. Chairman.

Chairman **Jacobs**. Ms. Mikulski.

Ms. **Mikulski**. Thank you, Mr. Chairman. Just one last question.

There are two things that are impressive about the home health care field. No. 1, by the very services that you provide, you prevent costly institutionalization. But second, it essentially is an array of small businesses and often nonprofit businesses like the Visiting Nurses Association. My concern, in terms of the office of ODR versus intermediaries, is the timeliness of your reimbursement. It seems to me that with small businesses and small private-sector businesses and nonprofits, you don't have a large cash flow which recouping benefits over a 3- to 4-year process in no way mitigates your circumstances.

It would seem to me that you need your money fast because your cash flow margins are not that great so that you can turn around and keep operating. Am I correct that, therefore, an important function is this timeliness of response that ODR performs and therefore enables you to keep functioning in a way that is most effective?

Mr. **Healy**. That is correct. Even though I represent the Home Health Services & Staffing Association, which is a large corporation, a couple of our companies are made up of basically what are called franchise groups which are independent, small businessmen.

And you will find that most of these organizations may have 2 or 3 days of operating capital on hand. So any major disruption in the cash flow situation can be a disaster to them. And the ability to deal with an intermediary such as ODR is a great advantage to them.

Mr. HOWARTH. One of the significant pieces of that, if I might also respond, is that with an automatic claims processing capability, you look at the review of the claim right at the front end so that you know whether or not you are asking for something that is not medically covered under the medicare program. Then you don't get the retroactive denials that many providers have experienced through a postreview process that is really the only process that we find in other intermediaries.

So that is another facet of the cash flow area.

Mr. TURF. Congresswoman Mikulski, there is a second aspect to that that is not apparent to the committee that I think they should know about. First, let me state that our experience this past year has been, again, very businesslike and professional. I do our quarterly PIP reports, which stand for periodic interim payment reports, and we send them proper data and we are on a fine reimbursement system.

Second, what happens when you have all of these disallowances and it takes 3 or 4 years to win them back, the Federal Government is paying the interest charges. That is a proper medicare expense. You borrow more money to run your business.

Now, I daresay I would like HCFA to do a study of—for example, in our case, our administrative win-backs over 3 years and find out what did it cost in terms of interest.

Mr. HOWARTH. The fascinating portion of that which you address also is that in the transfer of the 713 providers to our State intermediary, we find that two of them were in significant financial trouble wondering whether they can stay in business and the reason for that is that the review of claims comes on the back end and because of the time that it takes to process those claims, the appeals process for those claims and no payment because of that appeal pending, that the cash flow is considerably disrupted.

Mr. TURF. To give you an example, as of 3 years ago, we still had some $8,900 waiting to be paid back to us. The intermediary can't pay it back, they say, because we haven't completed all the cases and they don't want to reopen the cost reports to do it. The cost report is the cost reporting function.

Now, I am not really questioning the correctness of that but the point is that when that happens, your medicare trust fund is paying it.

Ms. MIKULSKI. Thank you, Mr. Chairman. I have no further questions. The testimony was quite self-explanatory.

Mr. MOORE. Mr. Chairman, I have enjoyed the testimony of these gentlemen and certainly I will never know as much about home health care as they do. I did meet with the home health care agencies in my own congressional district and found that they are providing a very important service. While I supported the earlier medicare home health care coverage improvements, I haven't been convinced yet on this point.

The comment was made to the Congresswoman from Maryland in answering the question about needing this money back quickly, yet according to the staff information dated September 1983, when you look at the ranking of ODR against intermediaries in terms of claims processing time, they rank 61st out of 75 in processing time of 30 days or less. And when you look at the error rate in claims processing, ODR is higher than the national average by one-tenth of 1 percent.

You know the fact that you gentlemen are representing essentially only 14 percent—as I understand the testimony, of all health care agencies, 86 percent of them are using private intermediaries. And in your testimony you are telling me, if you are right, that we ought to scrap the whole intermediary system and have ODR do it all. You are telling me they do everything better than anybody else. I wonder what the taxpayers think about that. Hiring back a whole bunch of Federal Government people to process forms.

I am not sure that is the direction we want to go. So I am still not convinced but I am listening.

Thank you, Mr. Chairman.

Chairman JACOBS. A lot of the representatives are smiling back there.

Mr. HOWARTH. Would you allow comment on that?

Mr. HEALY. Mr. Moore, one of the things you might be overlooking is the consistency the ODR brings to the system. I deal right now with about 14 different intermediaries across the United States, including ODR, and what occurs is that you get a wide diversity of coverage determinations, of determinations on cost reporting, on what is allowable, what is not allowable, and I have found that when I go back to ODR, I will get the right answer, not always an answer I like, but I will get the right answer.

And I have found that the personnel that work in ODR are much more knowledgeable than the average personnel that I will find in a Blue Cross plan across the United States. I have also found out that the responsiveness of those personnel in ODR is much quicker. I can get an answer on a determination of coverage or on the allowance of an expense on a cost report within a day from ODR. I will wait weeks for the Blue Cross plan, if not months or years.

It allows consistency along the program so that the medicare beneficiaries get the same services and coverage, from State to State; this does not occur with the different intermediaries that you have now and it is ODR and its role that is helping protect the intermediaries get the same service.

Mr. MOORE. I am listening to what you are saying, but present some evidence to us that that is the case. Everybody that has medicare coverage across the country ought to be eligible for the same benefits. It ought not be different. If it is, demonstrate it to us so we can correct it.

What I can't understand is why you are the only people challenging the system. I don't know of anybody else except home health care agencies that are challenging it and you operate across the country. I don't understand that. Where are the hospitals, the clinics, the hospices, and where is everybody else who operates through private intermediaries?

Mr. TURF. They may not have the experience that we have.

Mr. MOORE. Well, that is one explanation.

Mr. HOWARTH. I think the hospices in fact are challenging that through us because the National Association of Home Care represents the hospice organizations as does the Washington State Association of Home Health Agencies.

Mr. MOORE. Well, why aren't they using ODR? Only 14 percent of you are?

Mr. HOWARTH. There are only two ODR providers in our county.

Chairman JACOBS. Mr. Russo.

Mr. RUSSO. Mr. Howarth, you indicated you wanted to respond to the point that Mr. Moore was making regarding the problems with ODR and delays. If they are so good, why do we have some of these statistics? I would like a response to that, too.

Mr. HOWARTH. I think there are at least two questions in Mr. Moore's comments that I would like to respond to if I could. One is that if you went and said ODR was the only choice to be an intermediary and do away with the others, we would be here saying the reverse in terms of we do need a choice; the American principle of at least an opportunity for choice.

Second, that the claims processing in fact is slow, as a matter of fact, most ODR providers are on periodic interim payments, PIP. So the actual payment of cash to the home health agency is timely even though the claim itself may be processed at some other time. What is more important is that you know the outcome of that claim while it is going through the process because you have your front end experience and you don't have the denials in the back end of the screens.

Mr. MOORE. I don't disagree with that. What we are hoping is that everybody is going to be treated that way through the intermediary system through the entire electronic system.

Mr. HOWARTH. Our difficulty again is that the intermediaries are only interested in processing the bill, not looking at coverage on the mechanical basis; whereas the admission in mechanical basis and response to coverage on mechanical basis.

Mr. MOORE. I asked to have the record left open to see that the administration answers those valid points.

Mr. HOWARTH. I might say also that for instance the Blue Cross system does not have within it and recognize that most of their claims funnel directly through Michigan and back out again do not have the ability to give an individual provider like mine their own unique patient number into the system so that as such I cannot produce a claim, put it through the system, have it come back to me with my patient number on it so that I can mechanically lay that against, interface it with my system.

Mr. MOORE. That is the kind of thing we are supposed to be able to do according to the administration.

Mr. HOWARTH. Supposed to be. It gets good lip service but in reality, it is not there.

Chairman JACOBS. We thank the panel for very useful testimony.

The final panel for today consists of the Alabama Department of Public Health, represented by Anne M. Smith; the American Home Health Care of Georgia, represented by Elaine R. Davis, and the Florida Home Health Services, dividing their 5 minutes between Gene Tischer and Howard Kolber.

Mrs. Smith, you may proceed.

STATEMENT OF ANNE M. SMITH, DIRECTOR, BUREAU OF PUBLIC HEALTH NURSING, DIVISION OF HOME HEALTH SERVICES, ALABAMA DEPARTMENT OF PUBLIC HEALTH

Ms. SMITH. Mr. Chairman, members of the committee, I am Anne Smith, and I am representing the Alabama Department of Public Health, Division of Home Health Services and the Alabama Association of Home Health Agencies.

The Division of Home Health Services in Alabama is the parent agency of 58 subunits which are located in the health department's nursing divisions of the county health department throughout the State. We represent at least 50 percent or more than 50 percent of the certified home health providers in Alabama.

I am the past president and a cofounder of the Alabama Association of Home Health Care Agencies. Our association represents 75 percent of the home health providers in Alabama.

The Division of Home Health Services and the association appreciate being able to come and present testimony today. The Division of Home Health Services in Alabama has been giving service since the beginning of the medicare amendments in 1966. We have been a direct dealing provider since that time. We wish to remain a direct dealing provider through the Office of Direct Reimbursement.

We have found that ODR has been a hard taskmaster, but has been very fair and has listened to our needs and has responded.

The proponents for dismantling ODR have really given no good reasons to my way of thinking. There are many reasons to maintain ODR. I will touch on only a few of these.

First of all, there is cost effectiveness. The cost for processing our claims will increase by $4,800 per month or $57,600 per year. These figures are for claims only and only at the level with which they are now being reported, hopefully services will increase, this cost will increase at that time. It does not include other training activities brought on by the transition.

ODR's low administrative cost has been used as a standard. We will no longer have this base. In fact, there will probably be no incentive to keep administrative costs down. Why should there be? There is nobody else to compare it with.

We all know that ODR is the only one of the fiscal intermediaries that has no other vested interest.

Most of the insurance carriers have large interests in hospital claims, and nursing home claims. We have noted very little interest in supporting early discharge from hospitals so that the less costly home health care can be used. Very few of them even include home health benefits in their health insurance benefits package. I think this is most interesting.

ODR has the interest and the mechanism to reduce administrative cost and has used this expertise to develop methods of reducing costs such as the tape-to-tape billing and the electronic and telecommunication processing of claims. These efforts have resulted in less paperwork and shorter reimbursement time. All of these are very important to rural county health departments who operate on extremely small budgets with little funds to fall back upon.

ODR is working on still another cost-saving procedure which will probably not be completed if this dismantling goes forward.

Who will do the development and the research when ODR is no longer available? The fiscal intermediaries have not initiated this on their own. It is true that some of them are taking tape-to-tape and electronic billing now, but this was merely to get ready for some of the providers who were being handled in this manner.

When the medicare amendments were written in 1965, they clearly stated that providers should have a choice to use an insurance carrier or to deal directly with the administration for reimbursement. This was further stated in the Reconciliation Act of 1980.

The laws and interpretations that have been written recently that disallow freedom of choice are not in keeping with the intent of the medicare law and are not in keeping with the American principle of fairness to all. I think it rather noteworthy that 36 of the approved fiscal intermediaries are in the Blue Cross/Blue Shield chain. Is this not a monopoly? It seems to me it is.

With no alternative, benefits will be limited to the arbitrary decision of a regional intermediary and the patient in need will be the one to suffer.

There must be consistency in interpretation. ODR has the system for this consistency. It should be used. Why is there the great urge to dismantle ODR when it has been proven efficient and effective. I urge you to please delay this plan until the Congress has had time to study and to act on the House bill 2841 which Ms. Mikulski has already introduced and has spoken on today.

Thank you for letting me be here.

Chairman JACOBS. Thank you, Ms. Smith.

[The prepared statement follows:]

STATEMENT OF ANNE M. SMITH, DIRECTOR, BUREAU OF PUBLIC HEALTH NURSING, DIVISION OF HOME HEALTH SERVICES, ALABAMA DEPARTMENT OF PUBLIC HEALTH

Mr. Chairman, members of the committee: I am Anne Smith and I am here today to represent the Alabama Department of Public Health, Division of Home Health Services, and the Alabama Association of Home Health Agencies.

The Division of Home Health Services is the parent agency for 58 subunits which are the nursing divisions of the county and district health departments throughout the State of Alabama. We represent more than 50 percent of the home health agencies in Alabama and make between 115,000 and 120,000 medicare home health visits per year.

I am a past president and one of the founders of the Alabama Association of Home Health Agencies. More than 75 percent of the certified home health providers in Alabama belong to the Association.

The Division of Home Health Services and the Association are most appreciative of the opportunity to be represented here today and to have the privilege of testifying before you in behalf of retaining the Office of Direct Reimbursement. We are grateful for your support and your efforts in this behalf.

The Division of Home Health Services of the Alabama Department of Public Health has been a provider of medicare home health services since 1966. At that time we were given a choice of intermediaries. We chose the Office of Direct Reimbursement (ODR) and have never regretted the decision.

We feel very strongly that ODR should be continued. Our immediate concerns for the retention of ODR are as follows:

1. Efficiency and Effectiveness of ODR

a. ODR has highly efficient and cost effective computer and claims processing capability. Claims can be handled more rapidly (48 hours) with electronic billing and within two weeks on tape to tape billing. Both of these services are available with ODR. We were planning to implement telecommunications electronic billing which requires even less secretarial and clerical time and less paperwork than our present tape to tape billing while at the same time assuring more rapid reimbursement. Although some insurance companies are prepared for tape to tape billing, few, if any, are prepared for electronic billing and start of care procedures. Therefore, we will have to relinquish the idea of electronic billing which would have resulted in a substantial cost savings.

Cost of processing claims with ODR is $2.73 per claim which is the second lowest in the nation. Blue Cross/Blue Shield of Alabama has a cost of $3.48 per claim. In addition, Blue Cross/Blue Shield of Alabama has an MIF (Medical Information Form) which is not required by ODR. A private agency in Alabama did a study to determine the cost of processing the MIF with each claim and found it to be $1.17. The difference in the cost of Blue Cross/Blue Shield and ODR billing and the processing of the MIF will increase the cost of medicare home health services provided by our agencies by more than $4,800 per month or $57,600 per year. As services increase this amount will increase. The training and education of a staff to a new system is expensive and time consuming and we have not yet arrived at a cost. The overall picture here is one of increased cost just to maintain the present level of service. This is certainly not the intent of the home health industry.

b. Without ODR the ability to compare administrative costs associated with the payment procedures among fiscal intermediaries will be greatly diminished, if not destroyed completely. ODR's low administrative costs have served as a standard for comparisons in the past. With only one fiscal intermediary in a state and no other choice for an agency, there will be no incentive for the regional fiscal intermediary to reduce administrative costs.

c. Educational and consultative services of ODR have been exceptional. ODR personnel have assisted in numerous workshops for clarification of coverage determination and interpretation of rules and regulations, and have arranged meetings between ODR personnel and providers for free exchange of ideas, problems, etc. Consultants assigned in all areas, such as nursing, accounting, policy and others, have assured help when needed. Interpretations of regulations and guidelines regarding service coverage have been strict, but fair, and although we do not always agree at least we have had the opportunity to express our opinions without fear of retribution. In fact, there has been a cohesiveness that has enabled us to work together to provide quality services for those in need. In talking with representatives from other agencies there has not existed the same type of consultation with other intermediaries.

2. Experimental studies

ODR is the only fiscal intermediary with the mechanism for experimental studies directed toward reducing claims processing costs, which in turn reduce medicare program administrative expenses. An example was the Memorandum of Understanding for payment of claims in which our agencies participated, and which enabled the reimbursement time to be greatly reduced. This has been most beneficial to our small rural health departments.

3. Data base

ODR has the most comprehensive and accurate home health data base in the nation. A base such as this is essential in determining realistic home health policy, reimbursement, and benefit procedures. If we expect the home health industry to grow and to be rally effective in the health care field we must continue expertise in this field. ODR has demonstrated the skill of a nonpartisan independent governmental agency in developing a comprehensive data base. We should support not destroy such efforts.

4. Determination of patient benefits

Elimination of ODR would limit patient benefits to the arbitrary decision of a regional fiscal intermediary with no internal Health Care Financing Administration check or balance. This was made very clear at a meeting I attended just last week. Obviously, the person making the decisions had little or no experience in home health services and was unprepared to even hear another opinion. Arbitrary decisions of this type do not prevent abuse of the program, but they do result in denials of bona fide services.

5. Vested interests

ODR is the only fiscal intermediary that does not have vested interests in other more lucrative types of insurance claims. In fact, home health is of so little interest to most of the carriers that they will not even include it as a covered service in their health insurance benefit packages. With the greater market in hospital claims, there has been no real push by insurance carriers to reduce hospital days or to encourage the utilization of the less costly home health services. A fiscal intermediary should be supportive of its providers.

6. No freedom of choice

Although the regulations have been changed or interpreted to allow the Secretary of Health and Human Services to assign providers to regional (state) fiscal intermediaries, it was clearly stated in Section 1816 of the Social Security Act and 42 CFR 421-103 or directly from HCFA (42 CFR 421-103) that providers have the option of receiving payment for covered services furnished to medicare beneficiaries directly from the Administration. It seems, therefore, very clear that it was the intent of Congress for providers to have a choice of fiscal intermediaries. Up to the present this has been our democratic process and, above all, the fairness concept. We have heard that the Administration wishes to reduce the number of fiscal intermediaries. ODR is only one fiscal intermediary so the rule of reduction would not be exceeded. Under these circumstances why are we to be denied the right of a choice? With the elimination of ODR we lose the only option for intervention from recalcitrant or uncooperative fiscal intermediaries. Even before the rules to destroy ODR have become a fact, providers in some states are already having difficulties with appointed fiscal intermediaries, but they have no privilege to elect another. Can you not imagine the "heavy hand" that will be used when there is no possibility of another fiscal intermediary?

7. Fiscal intermediary overload

If the remaining agencies in Alabama that are reimbursed directly by ODR transferred to Blue Cross/Blue Shield of Alabama, the bills being processed will be more than doubled. What is this going to do to reimbursement turn around time or to other fiscal intermediary activities? The agencies already served by Blue Cross/Blue Shield are rightfully concerned about time delays and availability of help when needed. One director of a private agency reported that they were already having difficulties and could foresee only an increase in their problems when claims were so greatly increased.

8. Consistency

Consistency in interpreting claims, financial data, and other medicare guidelines has been a goal of the fiscal intermediaries. This is impossible to achieve without some standard of interpretation. ODR has developed a system of national overview. This overview gives them an insight as to the administrative problems unique to each region and because they have this overview, they have been able to develop consistent application of the medicare regulations. It has been suggested that there should be consistency within each state. Medicare is a national program, therefore, there should be consistency across state lines for we are all supposedly working under the same regulations. HCFA should aim to achieve consistency across state lines and the best way of doing this is to use ODR as the benchmark that all intermediaries are tested against for interpretation of coverage policies, denial rates, processing times, interpretation of reimbursement policies, etc.

9. Cost report

The proposed rule states that the current year cost report would be transferred to the new fiscal intermediary. Since we are an official agency, the cost report is rather complicated and different from the average freestanding agency. It is believed that such a transfer would slow the final settlement.

10. President Reagan's Private Sector Task Force on Cost Control

The proponents of eliminating ODR have stated that this action is the desire of the Administration. How can this be true when President Reagan's own Private Sector Task Force on Cost Control has recommended retention of ODR. In its report the task force stated, "the dismantling of ODR will remove any element of competition in serving claims and will actually increase the cost of medicare programs rather than produce savings." Why are these recommendations being ignored?

11. Private enterprise

The hue and cry seems to be for private enterprise and we have no ax to grind with this attitude; however, private enterprise usually means competition, but in eliminating ODR and leaving only one fiscal intermediary for all state home health agencies there is no competition.

SUMMARY

We would like to further comment and also raise the question as to why it becomes so necessary to eliminate ODR since it has certainly demonstrated cost effectiveness, has the most comprehensive and accurate home health data base in the nation which is needed to determine home health policy, reimbursement and benefit procedures, and has provided excellent consultative services. Also, it is only one additional fiscal intermediary and is, therefore, not increasing the number to any great extent. Is HCFA more interested in pushing through a proposed regulation that has already resulted in the approval of Blue Cross/Blue Shield as the regional intermediary in 36 states (this borders on monopoly) than in really giving consideration to the true facts of cost and to Congressional intent?

ENDING

We are asking that you give serious consideration to the concerns that have been expressed here and support us by delaying the transfer of home health agencies from ODR until Congress has the opportunity to consider H.R. 2841 introduced by Ms. Barbara Mikulski. We again thank you for your support of this legislation and your continued support of home health services.

We thank you for having this hearing today and for the opportunity to speak in behalf of the retention of ODR.

Chairman **JACOBS**. Ms. Davis.

STATEMENT OF ELAINE R. DAVIS, PRESIDENT, AMERICAN HOME HEALTH CARE OF GEORGIA

Ms. **DAVIS**. My name is Elaine Davis, and I represent American Home Health Care of Georgia. It is important for me to have this opportunity to share with you my experience in dealing with both the regional intermediary and the Office of Direct Reimbursement. I, therefore, thank you for allowing me this forum to air my opinions.

As the executive director of a certified nonprofit home health agency, I see my responsibilities as twofold: First, to insure the successful operation of the agency within the parameters set forth in medicare guidelines promulgated under title XVIII. Second, to insure our patients to achieve their optimum level of independence within their physical functional limitations.

In order to accomplish both goals, it is imperative to have a good working relationship with the intermediary. I would like to share with you some of my experiences with my first intermediary, Blue Cross/Blue Shield.

When I became the administrator of American Home Health, I didn't know anything about home health industry so understandably I turned to my intermediary to clarify certain regulations. My questions were obviously not important because I never received an answer to any of my letters. Even telephone calls were not returned.

The ensuing frustration was heightened as I learned more and more regarding the regulations on my own. I began to understand that I could not trust my intermediary because their personnel simply did not comprehend the guidelines they were supposedly monitoring. The epitome of my frustration with Blue Cross was when I asked for, and insisted upon, receiving in writing an explanation regarding the process of figuring the cost cap in the aggregate. I finally received this information after a meeting with the president of Blue Cross in which I cited numerous inequities.

He assured me I would have no further difficulty in dealing with the Blues. I only found out at a later date—during an audit—that the information I had received from Blue Cross was incorrect. When I produced my letter showing the authorization and figuring cost cap aggregates, the auditor simply said: "That's just too bad."

That error on Blue Cross' part cost my agency $10,000.

As a side note, my latest episode in the continuing saga of what I call singing the blues was just a month or so ago when a Blue Cross auditor came into my office to settle the last report sent to them. He asked to see my advertising account. I replied that I didn't have one. He said he had seen my commercials on TV and knew that that cost money so where in the world did I code that expense. I assured him what he had seen were PSA's. He didn't know what that was so I explained to him that they were public service announcements given by the station to 501(c)(3) organizations. He then asked: "What's a 501(c)(3) organization?" I asked him how did he expect to audit a 501(c)(3) unless he knew what one was.

Needless to say, when the opportunity presented itself for me to change to directly dealing with ODR, I grabbed it.

Let me tell you about that change. When I call ODR, I get someone to return my call. When I write to ODR, I get a written response. When I ask for information, I get it. When I ask a question, I get an answer. I may not like the answer, but I do, indeed, get one.

The biggest change, however, is one of attitude. I don't feel like I have to fight ODR every step of the way. I don't feel like ODR is my enemy. I don't feel like ODR is out to destroy providers of home health and all of these things I felt with Blue Cross. That is not to say that ODR has made life easy for me. Quite the contrary. I have to provide more indepth detail and documentation to ODR than I ever did with the Blues which no doubt leads to a more comprehensive understanding on their part.

I am constantly in touch should any problem arise and I am glad for it. Up to now I have only discussed administrative problems. I could not, however, in all good conscience close without discussing the most important aspect of my business—the patient.

You would think that medicare is medicare nationwide. Not so. Even within Georgia, medicare varies greatly, depending on the interpretation of the intermediary. For example, I was present at a meeting held in Gainesville, Ga., where a medical review nurse for Blue Cross of Columbus emphatically stated she would not cover physical therapy for gait training on a mentally deficient patient since this service is definitely covered under medicare guidelines and my agency has seen this type of patient specifically asked her why. Her response was if the patient learned to walk, he just might wander out into the street and get hit by a car.

This type of arbitrary decision on the part of an intermediary is not just wrong but dangerous and leads itself to discrimination in the worst possible way.

In Georgia, a mentally deficient medicare beneficiary who requires gait training will have to be serviced by an agency who deals with ODR or he will be denied his right to this service by Blue Cross. My agency sees some very acute patients daily for a specified period of time. Blue Cross says this type of service is above the level of home care and, therefore, an automatic denial.

When agencies are on waiver, there is no recourse to these denials even though the denial is arbitrary and totally unfounded. What is to happen to the patients who are discharged from the hospital sicker and sooner under DRG's? Thank goodness we have some agencies who are dealing with ODR who can see these patients at the frequencies dictated by the illness or injury.

Of all my concerns regarding the demise of ODR, there is one that stands out as the most crucial. If ODR is forced to dismantle, then the National Blue Cross Association, who holds the vast majority of the contracts for regional intermediaries, will become the agent who will, in fact, be setting national health care policy under the auspices of interpretive guidelines.

You owe it to yourself, to your constituents and to every medicare beneficiary in this country to insure that there is always the opportunity to challenge, that there is always a comparison and that there is always above all else the rights of the beneficiary to choose home health and to be able to receive the needed services without the fear of unnecessary denials.

We leave it with you. Please do not orchestrate the demise of the Office of Direct Reimbursement.

Chairman **Jacobs**. Ms. Davis, you should probably try to develop a little color in your testimony. I am so tired of these dull presentations.

Mr. Tischer.

STATEMENTS OF GENE TISCHER, EXECUTIVE DIRECTOR, AND HOWARD KOLBER, REIMBURSEMENT DIRECTOR, FLORIDA HOME HEALTH SERVICES, INC.

Mr. **Tischer**. My name is Gene Tischer, with Florida Home Health. I have submitted a statement that I will ask to be put in the record. We were told we had 5 minutes each and we will take 2½ and do it as quickly as we can.

Mr. Chairman, I want to talk about computers real fast to answer the concern I think Mr. Moore may have. We deal with ODR. We dealt with Blue Cross and Travelers and we reassert the contentions presented by the previous panel and these two members of my panel now that that has been our experience, too, dealing with other intermediaries before we had the privilege of moving to ODR.

ODR does three things for us: Deals with eligibility, with billing, and with payments; eligibility is a crucial issue in south Florida. We have a large patient refugee population, a large Cuban refugee population. These people buy into part B and get a card. The following month they may not pay that premium and may be out of the medicare program and we do not know that because they have a card in their possession.

With ODR, on our tape-to-tape, the eligibility for that particular beneficiary is not valid. If we deal with Aetna, we will know in 5 to 6 weeks whether or not that beneficiary had medicare coverage at the time we delivered those services. Without the eligibility determination on a quick basis in south Florida, we could face serious financial consequences and we are a small business and I would like to see that in some impact statement because we could be delivering care 5 or 6 weeks down the road and find out from Aetna, "We are sorry but care was given to someone who stopped paying the part B premium and he is not eligible for care and never was and therefore we are not going to pay you."

ODR also accepts payment data, transmits payment data back to us on a computer basis and Aetna does not have that capability. I was interested with the administration this morning, Mr. Moore, when they said they were going to encourage these intermediaries to have the computer capability that ODR has. They were going to encourage it. And I submit that encouragement is something you don't have to put in your budget. If they are going to require these intermediaries to meet ODR's capabilities, they are getting into a budgetary item.

Aetna says they have asked for budget increases for EDP capability. HCFA has turned them down and there is no intention on anybody's part that I have been able to ascertain that it would ever go to the extent of having tape-to-tape eligibility determinations like ODR currently does nor the payment transmission data back to us like ODR currently does. The most they are talking about perhaps is a computerized billing process which for our needs is simply not enough.

Mr. Kolber now has some cost data from the individual agency point of view.

[The prepared statement follows:]

STATEMENT OF GENE TISCHER, EXECUTIVE DIRECTOR, FLORIDA HOME HEALTH SERVICES, INC.

My name is Gene Tischer and along with my colleague, Howard Kolber, I appear today on behalf of Florida Home Health Services, Inc. to speak against the Administration's proposed elimination of the Office of Direct Reimbursement (ODR) and to urge appropriate Congressional action to preserve this Office. Our perspective is formed by the serious and adverse impact ODR's elimination would have on our free-standing, private, not-for-profit home health agencies and the concomitant adverse impact on the Medicare Trust Fund.

Our presentation is in three brief parts.

First, I shall detail the computerization process we have established over the past several years with ODR and contrast that process with the dramatically reduced computer capabilities we would be able to employ with Aetna—the designated intermediary for Florida. Then Mr. Kolber shall present estimates of the significant increased costs we would incur (and that means Medicare would incur these increases also) in the transitional stage, and in subsequent annual periods thereafter if ODR is not preserved.

Finally, I shall briefly detail our 5 U.S.C. Section 601(d)—the Small Business impact requirement has not been satisfied by the NPRM under contest here.

Currently, we are fully computerized with ODR and have been for the past 3½ years. That means our computer talks directly to ODR's computer in Baltimore for all three basic program components via telephone lines:

(1) Eligibility (inquiries to determine the current status of a putative Medicare beneficiary);

(2) Billing (the submission of medical claims for payment); and

(3) Payment (the transmission of payment data back to our agency).

We are not computer to computer with all three categories. If we are forced to transfer to Aetna, we would not be computerized in any meaningful sense with respect to category (1) eligibility determination, and with respect to category (3) payments for claims submitted by us.

Only bills can be transmitted to Aetna.

The significant and adverse impact of not having elibility computerized is of great concern to us in South Florida due to the disapproportionate number of special beneficiary eligibility requirements presently in our large refugee population. Often times, we are asked to admit to the Medicare home health program individuals who for all appearances qualify for benefits in this program, but in actuality, have not maintained a qualified status and hence at the time of admission are not in fact eligible. Our computerized eligibility procedure with ODR lets us know within one week of start of care if the patient is a valid Medicare beneficiary. Aetna only notifies a provider when there is an eligibility denial. This notice will not be received for at least five weeks after start of care. During this time medical care is being rendered to the patient. Eligibility denial results in lost reimbursement to the provider which can result in serious financial difficulties.

I want to emphasize that all of these additional costs are just for one home health agency, and over 450 are involved in this dispute. Not one dollar of these many thousands, incurred by us, and millions for the country that will have to be spent will go to provide one iota of additional health care services to a single patient in the United States.

We appreciate this opportunity to appear before this Committee today and we hope that our input is of value.

Mr. Kolber. I just want to indicate that I worked for Blue Cross of Florida as a medicare auditor, supervisor and manager for 5 years before going to Florida Home Health Services. I have been there for 6 years.

Before I go into the cost data, ODR starts reviewing for medical necessity at the time we transmit the eligibility data.

The day we admit a patient, we submit start of care data to ODR. ODR then queries the Social Security Administration to verify that that patient is eligible for medicare and transmits eligibility data back to us. This is all done in a computer.

Aetna does not do that, and I have been told they have no plans to do this. If ODR is dismantled and the HCFA administration wants to do something to protect us, where do we go? I know of no intermediary in the country except for ODR that has this complete capability.

Home health agencies have been reimbursed on the PIP method of reimbursement. It is based on your total costs divided by your visits.

With the Aetna system they pay a claim as soon as they receive it. They don't do medical review. Therefore, an Aetna provider can overstate its medicare visits and, therefore, its PIP rate. If that provider ends up closing its doors, the administration is going to be stuck with the dollars they have overpaid that provider. It is very unlikely they will ever recoup that money.

As far as the costs are concerned, we were on a manual billing system when we first went to ODR. We switched in April of 1980 to the computerized billing system.

With that background I have estimated it will cost us an additional $20,600 every year if we had to switch to Aetna with the existing system because of the extra keypunch time and error factor involved.

In addition, we have estimated, having gone through two transitions of intermediaries, it would cost us a minimum of $18,000 to convert to Aetna. That is based on retraining a minimum of 22 staff members, over at least a 2-week period of time.

The final results would probably be even larger, but it is very difficult to measure. I would like my written testimony introduced into evidence.

Chairman JACOBS. It will be included.

[The prepared statement follows:]

STATEMENT OF HOWARD KOLBER, REIMBURSEMENT DIRECTOR, FLORIDA HOME HEALTH SERVICES, INC.

My name is Howard Kolber and as stated by my colleague, Gene Tischer, I appear today on behalf of Florida Home Health Services Inc. to urge Congressional action to preserve the Office of Direct Reimbursement [ODR]. I was a Medicare auditor, supervisor and manager for Blue Cross of Florida for 5 years and have been in my present position as Reimbursement Director with Florida Home Health Services, Inc. for 6 years.

Mr. Tischer has given a brief description of our computerized eligibilities, billing and payment system.

In south Florida, because of the large number of Medicare beneficiaries who participate in Part B only, (i.e., the Cuban refugees) eligibility verification is crucial to the home health agency. Via computer we are able to transmit start of care data to ODR and within one week (more frequently if so desired) ODR transmits eligibility data to us via computer.

The State designated intermediary, Aetna, does not, nor can it do this. Aetna does not query for Medicare eligibility until after they receive the monthly billing data from the provider. Even with computerized billing this is usually 3 weeks after the billing cut-off date. Adding another 2 weeks until the provider actually receives notice from Aetna of no Medicare eligibilty (because unlike ODR which is computerized in both directions, Aetna can only receive bills from the provider via computer; all other data is by paper) the agency has already rendered 5 to 10 weeks of care to the patient (5 weeks for an end of the month start of care; 10 weeks for a first of the month start of care), with no payment source.

When ODR receives start of care data from the provider they query the Social Security Administration, via computer, to establish medicare eligiblity. In additon, the proposed patient care plan, which is transmitted with the start of care data is reviewed by ODR's computer in order to verify that the agency is not overutilizing visits. Thus, with ODR, medical review begins at the start of care, not at the time of billing, and it continues during the billing cycle.

With Aetna, a provider is paid for services rendered regardless of whether or not the patient is eligible for Medicare benefits, and with no medical review until after the bills have been paid.

Most home health agencies are reimbursed on an interim basis under the Periodic Interim Payment method commonly referred to as the PIP method. The PIP rate is based on an agency's cost and total visits. By overstating visits an agency can increase its PIP rate. The Aetna payment system can lead to an overstatement of visits and PIP rate since there is no plan of treatment review. Aetna pays what they are billed. ODR pays what their computer review says is necessary and proper. Thus, with Aetna a fraudulent provider can intentionally overbill visits creating a large PIP overpayment. Then if the providers closes its doors, the medicare program can be stuck trying to prosecute the provider and recovering the money. The ODR system greatly minimizes the possibility of this happening.

Mr. Tischer made reference to added operating costs of the agency. Let's look at what additional costs our agency could incur if HCFA were to force us to Aetna. With Aetna, there would be more time spent by our CRT terminal operators since they would have to key punch in all payments from Aetna. With ODR, this is done automatically via computer and has, therefore, a zero error rate. With manual key punching of payments an error rate of up to 10 percent can be expected. This means up to 10 percent of the data entered must be corrected.

When we first computerized our billing system payments were manually entered. With that experience, we estimate the need of an additional CRT operator in our data processing department at an annual salary plus fringe benefits cost of $15,600 the first year, with annual increases thereafter, plus another terminal at a cost of $1,500 per year.

The additional time and cost of supervisory people that would be necessary to check and verify the manually entered data is estimated to be approximately $2,000 per year. Management level time would be approximately $1,500 per year. Thus, the total "additional" (and I emphasize that word) on-going cost is estimated to be $20,600 per year.

The costs to be incurred during transition from ODR to Aetna is projected to be $18,000. This is due to training of approximately 22 administrative staff, from secretaries to managers, for an average of 2 weeks. This does not take into consideration changes (and the related cost) to existing forms designed to meet ODR's requirements.

Mr. Tischer has one final comment.

We appreciate this opportunity to appear before this committee today and we hope that our input is of value. If you have any questions I will be glad to answer them.

Mr. MOORE. Thank you, Mr. Chairman.

The thing that comes out of this hearing that impresses me the most is I have never heard a Federal agency defended to the extent I have heard this one defended. Everything you people have said about how wonderful this group is is just the reverse of what I hear generally about the Government.

ODR is evidently the best we got. From what you all tell me, they are simply on the Moon. I don't disagree with what you are saying, although there is some evidence to the contrary. Don't let me be guilty of defending Blue Cross. We have crossed sabers with those folks many times.

Mr. Tischer, you used the words "require" and "encourage," referring to the testimony of Mr. Bourque. What I understood him to say was that they were going to try to encourage all intermediaries to handle all claims on an electronic basis and you were not going to be made to change to one that did not do so.

He didn't say he was only going to encourage, and the record will bear this out, intermediaries to take on electronic processing, he also said home health agencies were not going to be forced to change to ones that did not have this capacity.

Your comment is everybody ought to be doing that. I fully agree. But we are talking about you and your problems and not perhaps the entire medicare claims processing system.

Ms. Davis, you made the comment at the close, don't orchestrate the demise of ODR. We are not doing that.

The U.S. Court of Appeals had stated the HHS has the power to do this themselves. We are not doing anything. What you are asking us to do is, I assume, if the burden of proof is heavy enough, to pass legislation to prevent them from doing something they have the power to do.

I have listened to you and it is certainly worth looking at and we will look at it. But home health care services, which I am very much in support of, accounts for about 3 percent of medicare outlays, and the people who are testifying here are 14 percent of that 3 percent. That doesn't look like a groundswell in support of ODR.

I am not sure you have carried the burden of proof yet. If I was an employee of ODR, I would be taking great pride, in all the credit they have been given.

Mr. TISCHER. Mr. Moore, I think your statistical analysis is incorrect. I am saying that just because an agency is not with ODR does not mean it is not supportive of retention of ODR.

In our State, there are several that would like to be, but HCFA has prevented agencies from moving to ODR for the last few years.

Every agency I represent with the Florida association is in favor of the retention of ODR as a freedom of choice in case they get dissatisfied. Only 14 percent wanting to see ODR remain is incorrect——

Mr. MOORE. Assuming it is 90 percent—90 percent of 3 percent. You only account for about 3 percent of medicare. Where is everybody else, if this thing is so bad?

Mr. TISCHER. The hospitals are not threatened. If I am a home health agency, and ODR is eliminated, I have no choice, and it is the free-standing agencies that are faced with the monopolistic consequences of this. We won't have a choice; the hospitals do. Big difference.

Ms. DAVIS. There is also one other difference that I think is important. And that is the fact that when you go into the hospital to have an appendectomy, you will have it and within a given set of circumstances, you will be out in *x* number of times. In the home setting you have a different set of circumstances. There are a lot of things that can interplay in that patient's recovery. There are a lot of things that can slow it down, and a lot of things going on.

The family's intervention there is most important. You do not have a controlled environment, and because you don't have a controlled environment, you have a lot of things that could happen, and a lot of things that could go wrong, and a lot of things that could expedite. And for that reason you don't have the same kind of cut-and-dried issues as you do in a hospital or in a nursing home.

You do not have cut-and-dried issues in home care. It depends on what is going on with that patient at that point in time in that particular environment.

Mr. MOORE. It doesn't matter.

In one of the towns in my district, they are doing a better job of taking care of those patients than the hospitals but every case is different.

The hospitals will tell you the same thing. Everybody is different. Every patient is different.

You have to give us the information and carry the burden of proof and step in and stop what is essentially an administrative act of the Federal Government. I am listening to you.

The point you make is the fact that the only people that would have a choice would be you.

Mr. TISCHER. The free-standing home health agency, that is correct.

Chairman JACOBS. Ms. Mikulski.

Ms. MIKULSKI. I have no questions of this panel. They very eloquently stated support for my legislation, and I thank them for their testimony and the very concrete work they have done in the community. And I particularly appreciate your expression of concern about the impact this will have on the patient care as well as on fiduciary responsibility.

Chairman JACOBS. Mr. Tischer, you made a point. You said that the hospitals would have a choice, even in the absence of this agency. Would you elucidate?

Mr. TISCHER. In the notice of proposed rulemaking, there are designated regions. I am with ODR and if it is eliminated, as a free-standing home health agency, I will be assigned by HCFA to

Aetna. However, there is also an agency in my county which is a hospital-based agency, and Blake Home Health Care is with Florida Blue Cross because their hospital is.

If it is eliminated, Blake Home Health Care can stay with Blue Cross of Florida or go with Aetna. They will have a choice. They have a counterpart; I don't.

Chairman **Jacobs**. Thank you, and I thank the panel very much.

Ms. **Mikulski**. One final comment. I was very pleased to hear all of the accolades about ODR in Maryland, and I want the record to show that we Federal employees from Maryland are crackerjacks.

Chairman **Jacobs**. Certainly very sweet.

[Whereupon, at 12:45 p.m., the hearing was adjourned.]

[The following was submitted for the record:]

Alliance Visiting Nurse Association

2011 Glamorgan St., Suite B
ALLIANCE, OHIO 44601

"A UNITED WAY AGENCY"

Phone: (216) 821-7055

August 29, 1983

John J. Salmon, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
Room 1102 Longowrth House Office Building
Washington, D. C. 20515

Dear Mr. Salmon:

I would like to submit a written statement for the printed record of the public hearing on the proposed elimination of the Office of Direct Reimbursement to be held on Wednesday, September 14, 1983.

I ask that ODR be maintained. Our agency has already had one intermediary change in July, 1982. The amount of time involved doing the necessary paperwork as well as maintaining our patient visits considerably increased our cost during that period.

I have found the Office of Direct Reimbursement to be fair, efficient, and timely--especially compared to the poor communication I have encountered with other companies regarding private insurance patients.

If for no other reason than to act as a "yardstick" and promote consistency, ODR should be maintained.

In summary, I deserve a choice of intermediary.

Very truly yours,

ALLIANCE VISITING NURSE ASSN.

Polly J. Offenbecher

Polly J. Offenbecher
Director

bfs

Greenbrier County Health Dept.
HOME HEALTH AGENCY
Medical Arts Building
Ronceverte, WV 24970
(304) 647-4825

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WAYS AND MEANS
HEALTH SUBCOMMITTEE

COMMITTEE ON
RECEIVED
AUG 24 1983
WAYS AND MEANS

August 9, 1983

The Honorable Harley O. Staggers, Jr.
Congress of the United States
Washington, D.C. 20515

Dear Sir:

The members of the Greenbrier County Home Health Board request your assistance regarding two items that have a profound impact on the continuation of quality services to the people of this county. We think you will find the situation to be similar in many of the counties within your district.

1. We request your support for H.R. 2841, "The Medicare Fiscal Intermediary Admendments Act". Briefly, this act allows each provider (such as the Greenbrier County Home Health Agency) to elect payments be made either by the Office of Direct Reimbursement (ODR) of the Health Care Finance Administration, or by a fiscal intermediary. Without passage of this admendment ODR will be eliminated. Our agency has been involved with both systems and finds ODR far more responsive and efficient. In one instance, we have been waiting eight months for payment through Blue Cross-Blue Shield for charges which have already been determined allowable. The Private Sector Task Force on Cost Control recommended ODR be retained. The retention of ODR has many benefits which I will not attempt to detail here. Additionally, it is quite likely that money will be saved by retaining ODR when compared to using fiscal intermediaries. We feel H.R. 2841 deserves both your support and co-sponsorship.

2. We request your intervention with the Secretary of Health, Education and Welfare to allow subcontracting of nursing services under regulations governing hospice programs. Please refer to H.R. 3588. As you may know, Greenbrier County is attempting to initiate a hospice program. The Home Health program is operational but is always in a precarious financial position due to the low population density. These two programs offer different services to many of the same people. As the proposed regulations now stand, these people will be forced to select services from one, but not both, of these agencies. This means that the Hospice program will need

to duplicate the nursing services currently available through Home Health. It also means anyone desiring hospice programs must divest themselves of Home Health services. In rural areas this will be a financial disaster for both agencies.

Although the agencies are reimbursed only for direct contact hours, the geography of this area necessitates an extensive amount of time be consumed in travel. This factor and the low population density make it very difficult to maintain any degree of efficiency. If the proposed hospice regulations are allowed to stand, it is quite possible that Home Health will be forced to have a nurse drive 35 miles from Lewisburg to Quinwood to treat one patient while the hospice program will be forced to hire another nurse to drive that same route to treat that person's spouse. Add to this the fact that these programs will be splitting an already low population density and you create a situation where both programs will be forced to be drastically inefficient.

We feel that both programs need to succeed. These programs are, and should be, complimentary. If the proposed regulations are altered to allow hospice programs to subcontract for nursing services so long as they subcontract with another Medicare-certified provider, such as Home Health, both programs would be more efficient and financially justifiable.

It is requested that you urge the Secretary to re-write the regulations in order to allow hospice programs to subcontract nursing services with another Medicare-certified provider.

Thank you for your kind attention to these matters.

Respectfully yours,

H.B. Moore M.D.

Houston B. Moore, Jr., MD
Chairman, Greenbrier County
Board of Health

MaryAnna Hanna - MAH
Chairman, Greenbrier County
Home Health Agency - Advisory Board

Anita B. Shaver, RN
Greenbrier Co. HHA ABS

Sarah A. Morgan, RN SAM
Greenbrier Co. HHA

Robin G. Boothe, RN R.B.
Greenbrier Co. HHA

Thomas M. Moore, R. P. T.
Physical Therapist
Greenbrier Co. HHA
Thomas M. Moore

Stephen L. Sebert M.D.

Stephen L. Sebert, MD
Health Director, Greenbrier County

Lucille W. Moore

Lucille W. Moore, RN - Administrator
Greenbrier County Home Health Agency

William Nelson

William Nelson, Speech Therapist
Greenbrier Co. HHA and
Member, Advisory Board

Peggy J. Hoke, Clerk IV Peggy J. Hoke
Greenbrier Co. HHA

Yvonne Michael, Clerk IV
Greenbrier Co. HHA Yvonne Michael

R. E. Isom, Accountant
Greenbrier Co. HHA Ronald E. Isom

Illinois Council

September 9, 1983

OF HOME HEALTH SERVICES
1619 ASHLAND AVENUE
EVANSTON, ILLINOIS 60201
312 - 328-6654

TO: The Honorable Andy Jacobs, Chairman
Subcommitte on Health of the Committee on Ways and Means

FROM: Helen Heyrman, Executive Director
Illinois Council of Home Health Services

RE: The Administration's Proposed Elimination of the Office of Direct Reimbursement at the Health Care Financing Administration

The Illinois Council of Home Health Services is the professional association of home health providers in the state of Illinois. We represent over 85% of the certified home health agencies in Illinois. Their ability to provide quality home health services to Medicare patients will be enhanced by keeping ODR and with it the right of providers to a choice of intermediaries. We urge support of HR 2841, which would preserve ODR, and are opposed to the proposed rule to abolish ODR published in the August 2, 1983 Federal Register.

HCFA claims that the elimination of ODR would "result in more effective and efficient administration of the Medicare program," and offers as argument that the proposed rules are "in keeping with the President's goal to contract out to the private sector functions now performed by the government."

It is our contention that ODR performs functions which are not appropriate to the private sector. Most importantly, it serves as a resource for quality control of regional intermediaries:

(1) As a Medicare experimental intermediary, ODR can provide HCFA with tested ways to strengthen program administration. For example, it provides the only mechanism to experiment in reducing claims processing costs.

(2) ODR has the most comprehensive and accurate home health data base in the country. Such a base is essential to sound determination of home health policy and reimbursement and benefit procedures.

(3) ODR provides the only option to home health and other Medicare providers who encounter recalcitrant or uncooperative fiscal intermediaries. Elimination of ODR would limit patients' benefits to the arbitrary decision of a regional intermediary, with no internal HCFA check or balance.

President Reagan's own Private Sector Task Force on Cost Control (the Grace Commission) recommended that the plan to eliminate ODR be reconsidered, stating that:

> The plan will remove any element of competition in servicing claims....HCFA will lose the significant value ODR provides as an in-house laboratory for special analyses and demonstrations....There is valid reason to believe that the plan, if implemented, will actually increase cost (conservatively $1.2 million), rather than produce savings.

Another justification offered by HCFA for the abolition of ODR is that it would permit a consistent application of coverage and reimbursement rules by all providers serviced by a regional intermediary in a state, and would facilitate on-site review of home health agencies by the intermediaries. Medicare is a national program and should strive for consistent national standards. Without ODR to serve as a benchmark, there is no tested measure for cost-effectiveness or protection against arbitrary denials within the designated region. HCFA's own data show that ODR has the second lowest adjusted cost per claim of all the Medicare intermediaries. Figures for the fourth quarter of the 1982 fiscal year show that it cost anywhere from $2.28 to $4.68 to process each claim. ODR was second lowest in cost to the government with average costs of $2.73 per claim.

Because there is serious doubt that elimination of ODR would result in effective cost control, we advocate that the Congress act to preserve the Office of Direct Reimbursement.

Illinois Council of Home Health Services
1619 Ashland Avenue
Evanston, IL 60201

**METRO
HOME HEALTH
SERVICES, INC.**

A Non-Profit Organization

728 W. Peachtree Street, N.W.
Atlanta, Georgia 30308
Telephone: (404) 892-6863

September 2, 1983

John Salmon, Chief Counsel
Committee of Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Salmon:

We believe it is important that the option of the Office of Direct Reimbursement be retained for all home health agencies. In addition, ODR acts as a safety valve for all agencies, keeping the process competitive and serving to upgrade the performance of all intermediaries.

Specifically, the Office of Direct Reimbursement should be retained for the following reasons:

1. ODR serves as a resource for quality control of regional intermediaries.
2. ODR has consistently had one of the lowest processing costs-per-claim rates of any intermediary. This is all the more important when HCFA's own data shows for the fourth quarter of the fiscal year 1982 (latest quarter data available) the cost-per-claim for ODR was $2.73 making it the second lowest of the 78 intermediaries.
3. ODR can be the Medicare experimental intermediary providing HCFA with on-the-scene resources for testing ways to strengthen program administration.

Furthermore, President Reagan's Private Sector Task Force on Cost Control recommended that the proposed plan to eliminate ODR be reconsidered specifically for some of the reasons mentioned above.

For these reasons, we strongly urge you to reconsider your decision and not close the Office of Direct Reimbursement.

Thanking you in advance for your consideration in this matter, we remain,

Sincerely,

Ronald S. Silvers
Administrator

cc: Congressman Wyche Fowler

Registered Nurses / Medical Social Work / Physical Therapy / Home Health Aide
Speech Therapy / Occupational Therapy / Nutritional Guidance

National
Council of
Health Centers

2600 Virginia Ave. N.W. Suite 1100 Washington, D.C. 20037 (202) 298-7393

STATEMENT
SUBMITTED FOR THE RECORD
TO
HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
ON THE
PROPOSED ELIMINATION OF THE OFFICE OF DIRECT REIMBURSEMENT
AT THE HEALTH CARE FINANCING ADMINISTRATION

September 14, 1983

STATEMENT
SUBMITTED FOR THE RECORD
TO
HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
ON THE
PROPOSED ELIMINATION OF THE OFFICE OF DIRECT REIMBURSEMENT AT THE HEALTH CARE FINANCING ADMINISTRATION

September 14, 1983

The National Council of Health Centers appreciates the opportunity to submit its comment on the proposals of the Health Care Financing Administration (HCFA) to contract out the functions of making payment determinations, disbursing payments and other activities with respect to providers that are currently serviced directly by the agency's Office of Direct Reimbursement (ODR). These proposals, which were published in the Aug. 2, 1983 Federal Register, are seen by many as a major step toward the elimination of ODR.

Members of the National Council are investor owned multi-state nursing home corporations which own or manage approximately 200,000 nursing facilities in 48 states and the District of Columbia. Our member firms also provide many other health related services such as home health, alcohol and drug rehabilitation programs, retirement centers and hospice services.

The National Council supports responsible efforts by the federal government to improve the effectiveness and efficiency in the administration of the Medicare program. HCFA's proposals are in keeping with President Reagan's philosophy of contracting out to the private sector many functions now performed by the federal government. Certainly, the withdrawal of HCFA from the direct claims processing business is an effort by the Administration toward reaching that goal.

We strongly support HCFA's proposal to allow chain organizations to be serviced by a single intermediary. We believe that such an option represents the potential for best utilization of the limited resources available to the federal government and providers, particularly as they relate to the provision of long term care services. Approaches and practices such as allowing the use of a single intermediary by chains enable the federal government and providers to more efficiently carry out the policies and programs of Medicare.

The National Council is delighted that HCFA now realizes that a chain organization dealing with a regional intermediary often decreases the ability of those entities to improve administration and program effectiveness. There are numerous cases in which the degree of centralization of a chain make it more efficient for a single intermediary to handle the home office audit and desk review of the chains providers cost reports, determine the scope of provider audits, perform final settlement of individual provider cost reports, and perform other activities.

This particular provision is important in light of a comprehensive 1981 study [1] which revealed that many of Medicare's administrative policies are a major cause of nonparticipation by providers in the program. That study, mandated by the Omnibus Budget Reconciliation Act of 1980 (PL 96-499), examined the reasons as to why skilled nursing facilities are not participating in Medicare.

The study found that claims reviewers in intermediaries made very different Medicare coverage decisions in identical cases, and that inconsistent intermediary interpretations often denied Medicare benefits to some recipients and awarded similar patients different benefits. In addition,

> "Even when reviewers agreed on awards or denials, they
> frequently used different rationals for their

> decisions. Furthermore, whether they agreed or disagreed on coverage, reviewers measured and assessed criteria for coverage -- stability,' the practical' need for institutional care, restoration potential' -- in different ways." [2]

The study found other variations in intermediaries' procedures:

> "Some intermediaries apply rules to classes of cases. Others base all coverage decisions on the specific record of each case. Some intermediaries tell the provider how many days they can expect in advance of service delivery. Others make all decisions retroactively. These differences in approach undoubtedly mean that some beneficiaries receive more benefits than others, despite similarity in their conditions." [3]

This wide array of coverage and claims review, and discrepancies in the application of standards by intermediaries have a devastating impact on the ability of multi-state chain organizations to provide the most effective and efficient methods of administrating Medicare.

We believe these differences in program administration make the merits of dealing with a single intermediary quite obvious. A single intermediary would ensure more uniform and consistent application of Medicare program policies and procedures. A single intermediary would have the potential of becoming an expert in handling the problems which may occur within a chain organization and its providers. A single intermediary would improve Medicare's ability to detect operational differences and help bring about corrective measures in a timely manner. Lastly, a single intermediary would be able to develop a comprehensive data base for cost reimbursement and monitoring activities.

The National Council's nursing home firms have found considerable economies of scale and consistence of operation in dealing with a single intermediary. Moreover, our member organizations have invested much time, effort and expense in automated means of interfacing with a single intermediary. The results of such a relationship have been beneficial to the federal government, providers and consumers in reducing inefficiencies and maximizing effectiveness in the administration of Medicare.

Finally, we want to relate some questions concerning the potential costs of HCFA's contracting out proposal. Currently, more than 1,200 providers are directly serviced by the agency. The requirement that all of those providers must now deal with intermediaries under HCFA contract will result in considerable savings in the agency's budget. But it is very difficult to perceive any real savings in total Medicare program costs. We believe that hidden additional costs will be found in the budgets of intermediaries that may be passed on to providers and ultimately the consumer. Perhaps the appropriate congressional committees should examine the impact of such a proposal on long term care and the health care system of our country.

The National Council is ready to work with Congress, HCFA and consumer groups in implementing any proposals that would improve the effectiveness and efficiency of administrating the Medicare program.

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[1] Judith Feder and William Scanlon, "Medicare and Medicaid Patients' Access to Skilled Nursing Facilities," Working Paper 1438-02, Washington, DC, The Urban Institute, November 1981.

[2] Ibid.

[3] Ibid.

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

Steven E. Katz, M.D.
Commissioner

Quality Assurance and Finance Division
JOANNE K. HILFERTY, Deputy Commissioner

September 22, 1983

Mr. John Salmon
Chief Counsel
Committee on Ways and Means
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Salmon:

The New York State Office of Mental Health (OMH), on behalf of the 32 Medicare providers it operates, submits these comments in response to the Congressional hearing of September 14, 1983, regarding continued funding for the federal Office of Direct Reimbursement (ODR) within the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS). The phase-out of this office has been proposed in previously issued federal Notices of Proposed Rulemaking (NPRM) published August 2, 1983 (Vol. 48, No. 149, pp. 34979-85), and February 19, 1982 (47 CFR 720). The phase-out would remove a participating Medicare provider's option to deal directly with ODR by permitting HCFA to contract with another fiscal intermediary for the purpose of making payments to a provider even if that provider currently has elected to receive payments from the provision of Medicare reimbursable services directly from ODR. Furthermore, it would remove such option in a precipitous fashion that would not enable providers to make a reasonable, well-planned transition to an alternate intermediary.

OMH has, since the inception of the Medicare program in 1966, dealt directly with ODR. In the first NPRM proposing the elimination of ODR it was stated:

> "At this time, it is not our intention to eliminate all direct dealing with hospitals and SNF's from ODR's workload. For example, we do not now expect to eliminate New York City and New York State hospitals, Federal hospitals, and hospitals and SNF's in Puerto Rico from the ODR workload. However, we may do so in the future."

At that time, OMH submitted comments in opposition to the proposed phase-out and the elimination of the option for direct dealing providers even though the New York psychiatric hospital network was specifically exempted from the proposal (copy attached).

We were appalled to learn from the NPRM issued on August 2, 1983, that the administration still sought to phase out ODR. OMH submitted comments regarding this recent notice within extremely restrictive timeframes permitted for comment (copy attached). Given the far-reaching implications of the proposal, two weeks was an unreasonably short period for public comment.

Many additional concerns were raised by the proposal. According to the NPRM, the transfers were to begin with the start of the next federal fiscal year, October 1, 1983, and be completed by September 30, 1984. For OMH, the transfer would occur by April 1, 1984, the beginning of New York's fiscal year. The six months remaining for the proposed effective date of the transfer is simply not adequate to allow for the resolution of outstanding issues between OMH and ODR or to make the necessary systems conversions in a well-planned manner. Moreover, if the change were implemented as proposed, OMH could not effectively exercise its option of nominating a preferred intermediary as provided in Section 1816 of the Social Security Act, since we could not make a thorough investigation of the experience of potential intermediaries in the time allocated. Neither could we review the qualifications of agencies which are currently not designated as intermediaries, but are considering seeking such an authorization.

The OMH network of hospitals is a large and complex system which represents a considerable workload comprising annual expenditures of $1.2 billion to support 32 Medicare certified hospitals throughout New York State. The system provides over eight million days of care per year and about two million outpatient visits annually. Roughly 16,000 OMH inpatients are Medicare eligible, resulting in over five million Part A and Part B days billed annually.

The intermediary must process and pay these billings as well as review detailed cost reports submitted by OMH for each of its 32 providers, calculate a final settlement amount for Medicare reimbursement purposes and conduct on-site fiscal audits of the OMH system. We are concerned about an intermediary absorbing this workload without OMH having an opportunity to assess their ability. We have no assurances that HCFA will provide adequate safeguards to prevent a disruption in the cash flow of Medicare revenue to OMH. This potential disruption could have a severe, untoward effect since our appropriation levels demand that our expenses be offset by receipts in revenue from these billings.

We also have no evidence that any new designated intermediary could handle technical processing requirements. Once an intermediary is selected, adequate lead time will be required to plan for and implement all technical aspects of the transition.

In addition, there are a number of outstanding, long-standing disputes between OMH and ODR that must be resolved prior to the elimination of ODR. These issues include:

- OMH currently has pending before the Provider Reimbursement Review Board (PRRB) two separate appeals, involving six cost-reporting years.
- Cost reports have been reopened as a result of the the submission of retroactive claims, dating back to New York's 1972-73 fiscal year.
- ODR has initiated an extensive multi-year audit program, covering all OMH operated providers for four cost-reporting periods. ODR has advised OMH that it intends to re-issue Notices of Provider Reimbursement for these years which should lead to continuing discussions regarding the results of the audits.

It seems unlikely that the outstanding issues between ODR and OMH can be resolved by April 1984. Transferring to a new intermediary would unduly penalize OMH in light of the extensive negotiations and preparation of requested documentation, which have already taken place regarding most of these issues. At least an additional year will be required to resolve such issues.

In summary, we believe the issues identified in these comments require postponement of any decision regarding the phase-out of ODR as a direct dealing provider for at least another year. For OMH, this would mean April 1, 1985, the start of the next fiscal year. A postponement to this date would allow OMH the opportunity to exercise its option to select and nominate an intermediary acceptable to OMH and HHS, as well as complete systems conversion work already nearing completion, and resolve ODR and OMH outstanding issues.

We appreciate the opportunity to present our views regarding the continued functioning of ODR for federal fiscal year 1983-84, and request your assistance in obtaining the necessary extension.

Sincerely yours,

Joanne K. Hilferty /df
JOANNE K. HILFERTY
Deputy Commissioner

NEW YORK STATE
OFFICE OF MENTAL HEALTH - 44 Holland Avenue, Albany, New York 12229

William F. Morris
Acting Commissioner

Quality Assurance and Finance Division
JOANNE K. HILFERTY Deputy Commissioner

September 1, 1983

Health Care Financing Administration
U.S. Department of Health and
Human Services
Attention: BPO-28-P
P.O. Box 26676
Baltimore, MD 21207

Re: File Code BPO-28-P

Administrators:

The New York State Office of Mental Health ("OMH") on behalf of the thirty-two Medicare providers it operates, submits these comments in response to the Notice of Proposed Rulemaking ("NPRM") published on August 2, 1983 at 48 Fed. Reg. 34979. The proposed regulations modify a participating provider's option to deal directly with HCFA (through the Office of Direct Reimbursement (ODR)) by permitting HCFA to contract with any organization for the purpose of making payments to a provider that has elected to receive payments directly from HCFA. In the Supplementary Information part of the NPRM it is stated that HCFA intends to exercise this authority for all providers presently dealing directly with ODR, with the possible exception of multi-state demonstration projects.

The Medicare providers of the OMH have, since the start of the Medicare program in 1966, dealt directly with HCFA. In the NPRM, published on February 18, 1982, (47 FR 7269) first proposing the elimination of hospital Medicare provider's option to deal directly with HCFA, it was stated:

> "At this time, it is not our intention to eliminate all direct-dealing hospitals and SNF's from ODR's workload. For example, we do not now expect to eliminate New York City and New York State hospitals, Federal hospitals, and hospitals and SNF's in Puerto Rico from the ODR workload. However, we may do so in the future."

Until this month, we had received no indication of any change in this stated intention, and OMH has proceeded accordingly.

A variety of concerns for OMH are raised by the proposed transfer of payment functions now handled by ODR to an intermediary organization. It is stated that the transfer is to be handled in a phased manner in order to assure an orderly transition. The transfers are to begin with the start of the next federal fiscal year, October 1, 1983, and to be completed by September 30, 1984. For the provider, the transfer is to occur at the beginning of its fiscal year. OMH's fiscal year is that of the State of New York; thus, transfer is proposed to take place on April 1, 1984.

Our primary concern is that seven months, the period between now and April 1, 1984, the proposed effective date of the transfer, is not adequate to allow for the resolution of key issues and to provide for an orderly transition of the intermediary functions. Nor, would this allotted time allow OMH the opportunity, as promised in the NPRM, to exercise its option of nominating an intermediary as provided in Section 1816 of the Social Security Act. To do so effectively, requires that OMH thoroughly review the performance of current intermediaries and other possible organizations which might serve as an intermediary. We believe that a proper transition is not feasible any earlier than the start of the subsequent fiscal year, April 1, 1985.

The OMH Provider System is a very large and complex organization which represents a very considerable workload to a Medicare fiscal intermediary. OMH's total annual expenditures of $1.2 billion go to support a large network of providers across New York State. The OMH System provides over 8 million total patient days of care per year and about 2 million outpatient visits per year. In terms of the Medicare Program, approximately two-thirds of OMH's patients are Medicare eligible, resulting in about 5.5 million patient days per year being billed to Medicare Part B and about 150,000 days per year being billed to Medicare Part A.

A Medicare fiscal intermediary is responsible for some very major activities for this extremely large and complex health care system. The activities include the processing and payment of Medicare bills submitted by OMH (5.5 million days of care) rendered to Medicare eligible patients. It includes the review of detailed cost reports submitted by OMH for each of its Medicare providers (over $1.2 billion in total expenses) and the calculation of final settlement amounts for Medicare reimbursement purposes. It also includes conducting on-site fiscal audits of the OMH system.

In addition to the work that it would take to properly transition these major responsibilities for OMH's large and complex health care system to a new fiscal intermediary, there are other issues and items relating to OMH that need to be fully considered in any proposed transfer of the fiscal intermediary function. The first of these are general issues relating to the selection of a new fiscal intermediary. The second is to ensure that the major systems' initiatives now underway by OMH relating to the Medicare reimbursement process are not disrupted. The third is the numerous outstanding and often complex issues that need resolution before a transfer can take place.

General Issues

There are a number of general issues that must be discussed and satisfactorily resolved to ensure that the best intermediary is selected for OMH and that the selected intermediary is provided the proper framework for its dealings with OMH. A very major issue is that OMH's Medicare providers are geographically distributed throughout the State of New York. As an agency of the State, however, OMH is highly centralized. For example, Medicare cost reports and all Medicare billings are done centrally. As part of the intermediary selection process, there should be a discussion and resolution of how the fiscal intermediary would handle such a system.

A second issue relates to how audits would be performed to ensure that uniform audit programs and determinations are made across the State.

A third issue is to ensure that there is a full understanding of the billing and payment processes and assurance that there will not be any disruption in cash flow to OMH. Discussion needs to take place relating to whether the intermediary can handle tape-to-tape billing, which OMH currently does with ODR.

A fourth issue is that the new fiscal intermediary must have adequate staffing and expertise to handle a system as large and complex as OMH. Discussion needs to take place to ensure that appropriate staff will be assigned to OMH.

OMH'S Major Systems Initiatives

OMH currently has underway two major systems initiatives which directly relate to the Medicare billing, payment and cost settlement activities. The first of these initiatives is the implementation of a new Medicare billing system. The second major initiative is the implementation of an outside computer software package to produce Medicare cost reports. Both of these initiatives are very important, not only to OMH, but also to the Medicare fiscal intermediary. As such, there should not be any disruption to the full implementation of these projects. A change in intermediaries as of April 1, 1984 before these projects are fully completed and operational could jeopardize their timely completion.

For a new intermediary to take over prior to the implementation of these projects would also entail considerably greater overall transfer costs, since it would be necessary for the intermediary to first master the existing billing and cost reporting systems.

Unresolved Issues Between OMH and ODR

OMH currently has pending before the Provider Reimbursement Review Board ("PRRB") two separate appeals, involving six cost reporting years. In addition, cost reports have been reopened, as a result of the submission of retroactive claims, dating back to state fiscal year 1972-73. In accordance with agreements entered into between the parties and approved by the PRRB, will be reissuing Notices of Program Reimbursement ("NPRs") for four separate cost years to reflect the resolution of numerous issues currently being negotiated between ODR and OMH. ODR has initiated an extensive multi-year audit program, covering all OMH operated providers for four cost reporting years. ODR has advised OMH that it intends to reissue NPRs for all providers for these years to reflect the application of this audit program as well.

Whether all these outstanding issues could be resolved before the beginning of OMH's next fiscal year, April 1, 1984, is most unlikely. Whether all these outstanding matters could be simply "transferred" to a new fiscal intermediary is equally unclear and would be unfair to OMH, given the extensive negotiations over the past year with ODR. Under the terms of the NPRM, however, there is no provision for a modification of HCFA's schedule in order to accommodate these pending matters.

All the issues identified in this letter, taken collectively, require that the selection of and transition to a new fiscal intermediary be done very carefully and in an orderly manner. The time provided for under the proposed regulations (seven months), is not adequate for all the activities that are necessary to provide for a smooth transition. In OMH's view, a transition to a new fiscal intermediary should not take place any earlier than April 1, 1985. An April 1, 1985 date should allow for a proper selection of an intermediary, resolution of current issues which effect future years, allow OMH to conclude the implementation of major systems initiatives which benefit both the fiscal intermediary and OMH, and allow for an orderly transition.

We appreciate the opportunity to comment on the proposed regulations.

Sincerely,

Joanne K. Hilferty

Joanne K. Hilferty
Deputy Commissioner
Quality Assurance & Finance

NEW YORK STATE
OFFICE OF MENTAL HEALTH

JAMES A. PREVOST, M.D. Commissioner

March 3, 1982

Ms. Carolyne K. Davis
Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 17073
Baltimore, Maryland 21235

Dear Ms. Davis:

The New York State Office of Mental Health serves a substantial number of Medicare recipients in 31 psychiatric centers. Our office claims reimbursement for these services from the Medicare program directly through the Office of Direct Reimbursement (ODR) within the Health Care Financing Administration. It has come to our attention that the Department of Health and Human Services proposes the abolition of ODR as an intermediary for Medicare claiming purposes.

The proposed regulations permit the exemption of New York State from this phase-out. However, we understand this to be a temporary exemption and that beginning in Federal Fiscal Year 1983-84 ODR will be completely phased out. Naturally, we are extremely concerned that this proposal was made without prior consultation or careful planning for a transition to another intermediary.

Since we account for over $50 million in ongoing, annual ODR payments, it is imperative that adequate preparation be given to any transition to another intermediary. We have no evidence that such planning has occurred and we have not received any assurances about the manner in which responsibility for payment of claims will be assigned should a new intermediary be appointed.

The proposal is particularly ill-timed, given our current efforts to overcome long-standing difficulties

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between New York State and ODR to clean up prior year billings. During the past 12 months substantial progress has been made. In addition, we have been working closely with ODR regarding the development of the Uniform Billing System, for submission of future claims, which would simplify future billings and permit a more orderly transition to another intermediary. A change in intermediaries at this time would require substantial duplication of these efforts.

This letter is to formally request that the elimination of ODR be stayed pending further study regarding the fiscal implications to direct dealing providers. We believe that a provider should continue to be afforded the opportunity to select its intermediary and that the option of continuing the use of ODR for claiming purposes should remain, not only for New York State, but also for all other direct dealing providers. If a provider decides to change intermediaries, a comprehensive plan to assure that cash flow is not interrupted should be developed. This plan should carefully spell out the responsibility for payment of current and retroactive claims.

Should you require further information, please contact Joanne K. Hilferty, Deputy Commissioner for Quality Assurance and Finance, at (518) 473-3861.

Very truly yours,

James A. Prevost

JAMES A. PREVOST, M.D.
Commissioner

c.c. Mr. Harry Schnibbe, Executive Director
National Association of State Mental Health
Program Directors